

Summary of Benefits

Humana USAA Honor Giveback (HMO) H4461-004

Tennessee

Our service area includes the following county/counties in Tennessee: Anderson, Benton, Blount, Bradley, Campbell, Cannon, Carter, Cheatham, Chester, Claiborne, Clay, Cocke, Coffee, Crockett, Cumberland, Davidson, Decatur, DeKalb, Dickson, Dyer, Fayette, Fentress, Franklin, Gibson, Giles, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hardeman, Hardin, Hawkins, Haywood, Henderson, Henry, Hickman, Houston, Jackson, Jefferson, Johnson, Knox, Lake, Lauderdale, Lawrence, Lewis, Loudon, Macon, Madison, Marion, Marshall, Maury, McMinn, McNairy, Meigs, Monroe, Montgomery, Moore, Morgan, Obion, Overton, Perry, Pickett, Polk, Putnam, Rhea, Roane, Robertson, Rutherford, Scott, Sequatchie, Sevier, Shelby, Smith, Stewart, Sullivan, Sumner, Trousdale, Unicoi, Union, Van Buren, Warren, Washington, Weakley, White, Williamson, Wilson.

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.

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 copays/coinsurance may change on January 1, 2026.
- 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.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).



Let's talk about Humana USAA Honor Giveback (HMO)

Find out more about the Humana USAA Honor Giveback (HMO) plan – including the health and drug services it covers – in this easy-to-use guide.

Humana USAA Honor Giveback (HMO) is a Medicare Advantage HMO 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](https://www.humana.com/PlanDocuments).

To be eligible

To join Humana USAA Honor Giveback (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name

Humana USAA Honor Giveback (HMO)

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](https://www.humana.com/Medicare)

More about Humana USAA Honor Giveback (HMO)

Do you have Medicare and Medicaid? If you are a dual-eligible beneficiary enrolled in both Medicare and the state's program, you may not have to pay the medical costs displayed in this booklet.

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 you must select an in-network doctor within the service area listed in this document to act as your Primary Care Provider (PCP). Humana USAA Honor Giveback (HMO) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services.



A healthy partnership

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



Monthly Premium, Deductible and Limits

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 \$105 but by no more than Original Medicare's Part B Premium for 2025.
Medical deductible	This plan does not have a deductible.
Maximum out-of-pocket responsibility	\$3,200 in-network The most you pay for copays, coinsurance and other costs for covered medical services for the year.



Medical Benefits

INPATIENT HOSPITAL COVERAGE

This plan covers an unlimited number of days for an inpatient stay **\$150** copay per day for days 1-5
\$0 copay per day for days 6-90

OUTPATIENT HOSPITAL COVERAGE

Diagnostic colonoscopy	\$0 copay
Diagnostic mammography	\$0 copay
Surgery services	\$250 copay

AMBULATORY SURGERY CENTER

Diagnostic colonoscopy	\$0 copay
Surgery services	\$200 copay

DOCTOR VISITS

Primary Care Provider (PCP)	<ul style="list-style-type: none"> • PCP's office: \$0 copay • Telehealth: \$0 copay
Specialist	<ul style="list-style-type: none"> • Specialist's office: \$25 copay • Telehealth: \$25 copay

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit [Humana.com/PAL](https://www.humana.com/PAL).



Medical Benefits (cont.)

H4461004000

PREVENTIVE CARE

This plan covers all Medicare preventive services including: **\$0** copay

- **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**
 - **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 **\$140** copay

If you are admitted to the same hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.

When placed in observation, member pays observation cost-share instead of emergency room cost-share.

Physician and professional services at emergency room **\$0** copay

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Medical Benefits (cont.)

URGENTLY NEEDED SERVICES

Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.

- Telehealth: **\$65** copay
- Urgent care center: **\$65** copay

DIAGNOSTIC SERVICES, LABS & IMAGING

Advanced imaging services (MRI, MRA, PET and CT scan)

- Freestanding radiological facility: **\$200** copay
- Outpatient hospital: **\$325** copay
- PCP's office: **\$200** copay
- Specialist's office: **\$200** copay

Basic radiological services (X-rays)

- Freestanding radiological facility: **\$50** copay
- Outpatient hospital: **\$130** copay
- PCP's office: **\$0** copay
- Specialist's office: **\$25** copay
- Urgent care center: **\$65** copay

Diagnostic mammography

- Freestanding radiological facility: **\$0** copay
- Specialist's office: **\$0** copay

Diagnostic procedures and tests

- Outpatient hospital: **\$25** copay
- PCP's office: **\$0** copay
- Specialist's office: **\$25** copay
- Urgent care center: **\$65** copay

Lab services

- Freestanding laboratory: **\$0** copay
- Outpatient hospital: **\$50** copay
- PCP's office: **\$0** copay
- Specialist's office: **\$0** copay
- Urgent care center: **\$65** copay

Nuclear medicine and services

- Freestanding radiological facility: **\$200** copay
- Outpatient hospital: **\$300** copay

Sleep study

- Member's home: **\$0** copay
- Outpatient hospital: **\$25** copay
- Specialist's office: **\$25** copay

Therapeutic radiology (Radiation therapy)

- Freestanding radiological facility: **\$0** copay
- Outpatient hospital: **\$0** copay
- Specialist's office: **\$25** copay

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Medical Benefits (cont.)

H4461004000

HEARING SERVICES

Medicare-covered hearing

\$25 copay

Mandatory supplemental hearing benefit

In-Network:

HER940

- **\$0** copay for routine hearing exams up to 1 per year.
- **\$399** copay for each Advanced level hearing aid up to 1 per ear per year.
- **\$699** 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 Premium and Advanced aids 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 (TTY: 711).

DENTAL SERVICES

Medicare-covered dental

\$25 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 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

In-Network:

DENF80

- Plan covers up to **\$2500** 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.
- **30%** of the cost applies to dentures.

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*



Medical Benefits (cont.)

be billed for charges that exceed the negotiated fee schedule (but any applicable coinsurance payment still applies).

Find a dentist in the nationwide Humana Dental Medicare network at Humana.com > Find Care.

- **30% - 40%** of the cost applies to bridges and crowns.
- Frequency limits may apply.
- Note: The allowance cannot be used on fluoride, cosmetic services and implants.

VISION SERVICES

Eyewear (post cataract surgery) **\$0** copay

Medicare-covered diabetic eye exam **\$0** copay

Medicare-covered vision services **\$25** copay

The provider locator for Medicare-covered vision can be found at Humana.com > Find Care.

Mandatory supplemental vision benefit

The mandatory supplemental vision benefits are provided through the Humana Medicare Insight Network. The provider locator can be found at Humana.com > Find Care.

In-Network:

VIS734

- **\$0** copay for routine exam up to 1 per year.
- **\$100** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.
- OR
- **\$150** maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.
- Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year.
- Maximum benefit coverage amount is limited to one time use per year.
- Maximum benefit coverage amounts cannot be combined.

PLUS providers are part of the Humana Medicare Insight Network and are indicated in the provider locator search results.

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit Humana.com/PAL.



Medical Benefits (cont.)

MENTAL HEALTH SERVICES

Inpatient

This plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital

\$150 copay per day for days 1-5
\$0 copay per day for days 6-90

Mental health therapy visits

- Outpatient hospital: **\$25** copay
- Partial hospitalization: **\$25** copay
- Specialist's office: **\$25** copay

Outpatient substance abuse services

- Outpatient hospital: **\$25** copay
- Partial hospitalization: **\$25** copay
- Specialist's office: **\$25** copay
- Telehealth: **\$25** copay

SKILLED NURSING FACILITY (SNF)

This plan covers up to 100 days in a SNF

\$20 copay per day for days 1-20
\$214 copay per day for days 21-100

AMBULANCE

Air

20% of the cost

Ground

\$315 copay per date of service

TRANSPORTATION

Not Covered

MEDICARE PART B DRUGS

Some rebatable Part B drugs may be subject to a lower coinsurance

Allergy shots and serum

- PCP's office: **\$0** copay
- Specialist's office: **\$0** copay

Chemotherapy drugs

- Outpatient hospital: **20%** of the cost
- Specialist's office: **20%** of the cost

Other Part B drugs

- Outpatient hospital: **20%** of the cost
- PCP's office: **20%** of the cost
- Pharmacy: **20%** of the cost
- Specialist's office: **20%** of the cost

Part B Insulin

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

- Outpatient hospital: **20%** of the cost
- PCP's office: **20%** of the cost
- Pharmacy: **20%** of the cost
- Specialist's office: **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 this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit [Humana.com/PAL](https://www.humana.com/PAL).

Prescription Drug Benefits

This plan covers Part B drugs including, but not limited to, chemotherapy and some drugs administered by your provider. However, this plan does not cover Part D prescription drugs.

Additional Benefits

Acupuncture services (Medicare-covered)	\$25 copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.
Chiropractic services (Medicare-covered)	\$20 copay
Podiatry services (Medicare-covered)	\$25 copay
MEDICAL EQUIPMENT/SUPPLIES	
Continuous glucose monitor (CGM)	<ul style="list-style-type: none"> DME provider 20% of the cost Pharmacy: 20% of the cost
Diabetic monitoring supplies	<ul style="list-style-type: none"> Diabetic supplier: 20% of the cost Network retail pharmacy: 10% of the cost Preferred diabetic supplier: \$0 copay
Durable medical equipment (DME)	<ul style="list-style-type: none"> DME provider: 20% of the cost
Medical supplies	<ul style="list-style-type: none"> Medical supplier: 20% of the cost
Prosthetic devices and related supplies	<ul style="list-style-type: none"> Prosthetics provider: 20% of the cost
REHABILITATION SERVICES	
Cardiac rehabilitation services	<ul style="list-style-type: none"> Outpatient hospital: \$10 copay Specialist's office: \$10 copay
Occupational therapy	<ul style="list-style-type: none"> Comprehensive outpatient rehab facility: \$20 copay Outpatient hospital: \$20 copay Specialist's office: \$20 copay
Physical therapy	<ul style="list-style-type: none"> Comprehensive outpatient rehab facility: \$20 copay Outpatient hospital: \$20 copay Specialist's office: \$20 copay
Pulmonary rehabilitation services	<ul style="list-style-type: none"> Outpatient hospital: \$10 copay Specialist's office: \$10 copay
Speech therapy	<ul style="list-style-type: none"> Comprehensive outpatient rehab facility: \$20 copay Outpatient hospital: \$20 copay Specialist's office: \$20 copay
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)	<ul style="list-style-type: none"> Outpatient hospital: \$10 copay Specialist's office: \$10 copay



More benefits with **this plan**

Enjoy some of these extra benefits included in this 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](https://www.humana.com/PlanDocuments) to view a copy of the EOC or call **1-800-833-2364**.

Humana Healthy Options Allowance™*

Members diagnosed with a qualifying chronic health condition may receive a **\$50** monthly allowance on a prepaid card to use for essentials you need to support your health.

This allowance can be used to buy approved products from participating retail locations (like groceries, personal care items, home supplies, etc.) or pay for approved services (monthly living expenses like rent, non-medical transportation costs like a taxi, Uber, Lyft, etc.).

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

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

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

See the Humana Spending Account Card section for more information.

Humana Spending Account Card

The Humana Spending Account Card is what you use to spend allowances included in this plan. If you currently have a Humana Spending Account Card please keep using it. Allowances will continue to be loaded to this card. If you do not have a card, one will be sent to you. Please activate your card as soon as you receive it in the mail.

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

HMO Travel Benefit

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

You must select an in-network doctor within the service area listed in this document to act as your Primary Care Provider (PCP).

* Benefit(s) mentioned may be part of a special supplemental program for chronically ill members with one of the following conditions: Diabetes mellitus, Cardiovascular disorders, Chronic and disabling mental health conditions, Chronic lung disorders, Chronic heart failure. This is not a complete list of qualifying conditions. Having a qualifying condition alone does not mean you will receive the benefit(s). Other requirements may apply.

Humana Well Dine® Meal Program
\$0 copayment for Humana Well Dine® meal program.

After your inpatient stay in either a hospital or a nursing facility, you may be eligible to receive 2 home delivered meals per day for 7 days (up to 14 meals).

Meals must be requested within 30 days of discharge from your inpatient stay.

Limited to 4 times per year.

Rewards and Incentives - Go365® by Humana

Complete eligible healthy activities, like preventive screenings and exams, and get rewarded.

SilverSneakers® fitness program
Live a healthier, more active life through fitness and social connection at participating locations and online.

Notice of Non-Discrimination

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Humana Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or by mail or phone at:

- U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019, 800-537-7697 (TDD)**.

This notice is available at **www.humana.com/legal/non-discrimination-disclosure**.

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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 quý vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý 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 대해 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 بخططنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY: 711) 1-877-320-1235. 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。



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