2025

Summary of Benefits

Humana Gold Choice H8145-004 (PFFS)

North Carolina & Virginia

North Carolina-Virginia

Our service area includes the following county/counties in North Carolina: Anson, Avery, Buncombe, Caswell, Catawba, Davidson, Davie, Forsyth, Gaston, Gates, Henderson, Madison, Mecklenburg, Rowan, Scotland, Watauga, Yancey
Virginia: Alexandria City, Amherst, Appomattox, Botetourt, Brunswick, Carroll, Chesapeake City, Chesterfield, Craig, Emporia City, Essex, Falls Church City, Floyd, Fredericksburg City, Galax City, Gloucester, Greensville, Halifax, Hampton City, Hanover, Harrisonburg City, Henrico, Isle of Wight, King George, Mecklenburg, Middlesex, Norfolk City, Northampton, Nottoway, Patrick, Petersburg City, Pittsylvania, Portsmouth City, Powhatan, Prince Edward, Pulaski, Richmond, Richmond City, Roanoke, Roanoke City, Rockingham, Salem City, Southampton, Spotsylvania, Stafford, Virginia Beach City, Westmoreland.

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

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or 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.
- ☐ This 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 situation, non-contracted providers may deny care. In addition, you may pay a higher copay/coinsurance for services received by non-contracted providers.

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Let's talk about Humana Gold Choice H8145-004 (PFFS)

Find out more about the Humana Gold Choice H8145-004 (PFFS) plan – including the health and drug services it covers – in this easy-to-use guide.

Humana Gold Choice H8145-004 (PFFS) is a Medicare Advantage PFFS 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 Humana Gold Choice H8145-004 (PFFS), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name

Humana Gold Choice H8145-004 (PFFS)

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 Humana Gold Choice H8145-004 (PFFS)

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). Humana Gold Choice H8145-004 (PFFS) has a network of doctors, hospitals, pharmacies and other providers.

A healthy partnership

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

Monthly Premium, Deductible and Limits

PLAN COSTS	
Monthly plan premium	**$18** If you receive premium assistance, this plan premium may be reduced. You must keep paying your Medicare Part B premium.
Medical deductible	**$750** out-of-network The following services listed are excluded from the out-of-network deductible: • Ambulance Services • Chemotherapy Drugs and Administration • Diabetic Monitoring Supplies • Emergency Room Services • Medicare Covered Preventive Services (including Immunizations (Flu & Pneumonia)) • Medicare Part B Insulin Drugs • Other Medicare Part B Drugs • Services not covered by Original Medicare • Urgently Needed Services at Urgent Care Centers
Pharmacy (Part D) deductible	**$0** deductible for Tier 1 and Tier 2 **$350** deductible for Tier 3, Tier 4 and Tier 5
Maximum out-of-pocket responsibility	**$7,550** combined in- and out-of-network The most you pay for copays, coinsurance and other costs for covered medical services for the year.

Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
INPATIENT HOSPITAL COVERAGE		
This plan covers an unlimited number of days for an inpatient stay.	**$330** copay per day for days 1-6 **$0** copay per day for days 7-90	**$330** copay per day for days 1-6 **$0** copay per day for days 7-90
OUTPATIENT HOSPITAL COVERAGE		
Diagnostic colonoscopy	**$0** copay	**$0** copay
Diagnostic mammography	**$0** copay	**$0** copay

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Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Surgery services	**$375** copay	**$375** copay
AMBULATORY SURGERY CENTER		
Diagnostic colonoscopy	**$0** copay	**$0** copay
Surgery services	**$350** copay	**$350** copay
DOCTOR VISITS		
Primary care provider (PCP)		
• PCP's office	**$0** copay	**$0** copay
• Telehealth	**$0** copay	**Not Covered**
Specialist		
• Specialist's office	**$45** copay	**$45** copay
• Telehealth	**$45** copay	**Not Covered**
PREVENTIVE CARE		
This plan covers all Medicare preventive services 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	**$0** copay

Medical 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 When placed in observation, member pays observation cost-share instead of emergency room cost-share.	**$100** copay	**$100** copay
Physician and professional services at emergency room	**$0** copay	**$0** copay
URGENTLY NEEDED SERVICES		
• **Telehealth** • **Urgent care center** Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical attention.	**$45** copay **$45** copay	**Not Covered** **$45** copay

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Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Advanced imaging services (MRI, MRA, PET and CT scan)		
• Freestanding radiological facility	**$160** copay	**$160** copay
• Outpatient hospital	**$325** copay	**$325** copay
• PCP's office	**$200** copay	**$200** copay
• Specialist's office	**$200** copay	**$200** copay
Basic radiological services (X-rays)		
• Freestanding radiological facility	**$40** copay	**$40** copay
• Outpatient hospital	**$130** copay	**$130** copay
• PCP's office	**$0** copay	**$0** copay
• Specialist's office	**$45** copay	**$45** copay
• Urgent care center	**$45** copay	**$45** copay
Diagnostic mammography		
• Freestanding radiological facility	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
Diagnostic procedures and tests		
• Outpatient hospital	**$120** copay	**$120** copay
• PCP's office	**$0** copay	**$0** copay
• Specialist's office	**$45** copay	**$45** copay
• Urgent care center	**$45** copay	**$45** copay
Lab services		
• Freestanding laboratory	**$0** copay	**$0** copay
• Outpatient hospital	**$45** copay	**$45** copay
• PCP's office	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• Urgent care center	**$45** copay	**$45** copay
Nuclear medicine and services		
• Freestanding radiological facility	**$325** copay	**$325** copay
• Outpatient hospital	**$325** copay	**$325** copay
Sleep study		
• Member's home	**$0** copay	**$0** copay
• Outpatient hospital	**$120** copay	**$120** copay
• Specialist's office	**$45** copay	**$45** copay

Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Therapeutic radiology (Radiation therapy)		
• Freestanding radiological facility	**20%** of the cost	**20%** of the cost
• Outpatient hospital	**20%** of the cost	**20%** of the cost
• Specialist's office	**$45** copay	**$45** copay
HEARING SERVICES		
Medicare-covered hearing	**$45** copay	**$45** copay
Mandatory supplemental hearing benefit	**HER947** • **$0** copay for routine hearing exams up to 1 per year. • **$99** copay for each Advanced level hearing aid up to 1 per ear per year. • **$399** 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).**	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
DENTAL SERVICES		
Medicare-covered dental	**$45** copay	**$45** copay
Mandatory supplemental dental benefit Limitations and exclusions may apply. Submitted claims are	**DENE70** • Plan covers up to **$2000** allowance every year for non-Medicare covered	**DENE70** • Plan covers up to **$2000** allowance every year for non-Medicare covered

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	IN-NETWORK	OUT-OF-NETWORK
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 any applicable 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.	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. • Frequency limits may apply. • Note: The allowance cannot be used on fluoride, cosmetic services and implants.	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. • Frequency limits may apply. • Note: The allowance cannot be used on fluoride, cosmetic services and implants. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
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 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. Find a dentist in the nationwide Humana Dental Medicare network at **Humana.com** > Find Care.		
VISION SERVICES		
Eyewear (post cataract surgery)	**$0** copay	**$0** copay
Medicare-covered diabetic eye exam	**$0** copay	**$0** copay
Medicare-covered vision services The provider locator for Medicare-covered vision can be found at **Humana.com** > Find Care.	**$45** copay	**$45** copay

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Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
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.	**VIS752** • **$0** copay for routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for routine exam. • **$200** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • OR • **$250** 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.	**VIS752** • **$0** copay for routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for routine exam. • **$200** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. • Maximum benefit coverage amounts cannot be combined.
MENTAL HEALTH SERVICES		
Inpatient This plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$345** copay per day for days 1-4 **$0** copay per day for days 5-90	**$345** copay per day for days 1-4 **$0** copay per day for days 5-90

Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Mental health therapy visits		
• Outpatient hospital	**$100** copay	**$100** copay
• Partial hospitalization	**$80** copay	**$80** copay
• Specialist's office	**$45** copay	**$45** copay
Outpatient substance abuse services		
• Outpatient hospital	**$100** copay	**$100** copay
• Partial hospitalization	**$80** copay	**$80** copay
• Specialist's office	**$45** copay	**$45** copay
• Telehealth	**$45** copay	**Not Covered**
SKILLED NURSING FACILITY (SNF)		
This plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$184** copay per day for days 21-62 **$0** copay per day for days 63-100	**$0** copay per day for days 1-20 **$184** copay per day for days 21-62 **$0** copay per day for days 63-100
AMBULANCE		
	$300 copay per date of service	**$300** copay per date of service
TRANSPORTATION		
The member ***must*** contact transportation vendor to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider.	**$0** copay for plan approved location up to 24 one-way trip(s) per year. This benefit is not to exceed 75 miles per trip.	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

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Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
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	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
Chemotherapy drugs		
• Outpatient hospital	**20%** of the cost	**20%** of the cost
• Specialist's office	**20%** of the cost	**20%** of the cost
Other Part B drugs		
• Outpatient hospital	**20%** of the cost	**20%** of the cost
• PCP's office	**20%** of the cost	**20%** of the cost
• Pharmacy	**20%** of the cost	**20%** of the cost
• Specialist's office	**20%** of the cost	**20%** of the cost
Part B Insulin		
• Outpatient hospital	**20%** of the cost	**20%** of the cost
• PCP's office	**20%** of the cost	**20%** of the cost
• Pharmacy	**20%** of the cost	**20%** of the cost
• Specialist's office	**20%** of the cost	**20%** of the cost
You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan.		

Prescription Drug Benefits

PLAN HIGHLIGHTS	
$0 copays	**$0** copays at select pharmacy locations and tiers. Additional details below.
Deductible	**$0** deductible for Tier 1 and Tier 2
Insulin costs	You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan.
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

DEDUCTIBLE

$0 deductible for Tier 1 and Tier 2. This plan has a **$350** deductible for Tier 3, Tier 4 and Tier 5 drugs. You pay the full cost of these drugs until you reach **$350**. Then, you only pay your cost-share.

INITIAL COVERAGE

You pay the following until your total yearly out-of-pocket drug costs reach **$2,000**. Once you reach this amount, you will enter the Catastrophic Stage.

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	$5	$15	$10	$30	$5	$0
Tier 2: Generic	$15	$45	$20	$60	$15	$0
Tier 3: Preferred Brand	$47	$141	$47	$141	$47	$131
Tier 4: Non-Preferred Drug	50%	50%	50%	50%	50%	50%
Tier 5: Specialty Tier	28%	N/A	28%	N/A	28%	N/A

You have several options for filling your prescriptions, including retail and mail-order pharmacies. CenterWell Pharmacy® is the preferred mail-order, cost-sharing pharmacy for many Humana plans, which means you may pay as little as **$0** for certain Tier 1 and Tier 2 generics. Learn more at **CenterWellPharmacy.com**.

Other pharmacies are available in our network. To find which pharmacies are available in our 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, even if you haven't paid your deductible.

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	$95
Tier 5: Specialty Tier	$35	N/A	$35	N/A	$35	N/A

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

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

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CATASTROPHIC COVERAGE

After your total out-of-pocket costs reach **$2,000** you pay **$0** for plan-covered Part D drugs.

EXTRA HELP

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

Prior to reaching your annual **$2,000** out-of-pocket limit you will pay one of the following depending on your level of "Extra Help:"

- **$4.90** for generic/preferred multi-source drug or biosimilar; **$12.15** for any other drug; OR
- **$1.60** for generic/preferred multi-source drug or biosimilar; **$4.80** for any other drug; OR
- **$0** for all drugs

After reaching your annual **$2,000** 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 (TTY: 1-800-325-0778), Monday – Friday, 7 a.m. – 7 p.m. 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
Acupuncture services (Medicare-covered)	**$45** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.	**$45** 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.
Chiropractic services (Medicare-covered)	**$15** copay	**$15** copay
Podiatry services (Medicare-covered)	**$45** copay	**$45** copay

Additional Benefits (cont.)

MEDICAL EQUIPMENT/SUPPLIES		
Continuous glucose monitor (CGM)		
• DME provider	**20%** of the cost	**20%** of the cost
• Pharmacy	**20%** of the cost	**20%** of the cost
Diabetic monitoring supplies		
• Diabetic supplier	**20%** of the cost	**20%** of the cost
• Network retail pharmacy	**10%** of the cost	**10%** of the cost
• Preferred diabetic supplier	**$0** copay	**Not Covered**
Durable medical equipment (DME)	**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		
• Outpatient hospital	**$15** copay	**$15** copay
• Specialist's office	**$15** copay	**$15** copay
Occupational therapy		
• Comprehensive outpatient rehab facility	**$15** copay	**$15** copay
• Outpatient hospital	**$35** copay	**$35** copay
• Specialist's office	**$15** copay	**$15** copay
Physical therapy		
• Comprehensive outpatient rehab facility	**$15** copay	**$15** copay
• Outpatient hospital	**$35** copay	**$35** copay
• Specialist's office	**$15** copay	**$15** copay
Pulmonary rehabilitation		
• Outpatient hospital	**$25** copay	**$25** copay
• Specialist's office	**$25** copay	**$25** copay
Speech therapy		
• Comprehensive outpatient rehab facility	**$15** copay	**$15** copay
• Outpatient hospital	**$35** copay	**$35** copay
• Specialist's office	**$15** copay	**$15** copay

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Additional Benefits (cont.)

Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD)		
• Outpatient hospital	**$20** copay	**$20** copay
• Specialist's office	**$20** copay	**$20** 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** to view a copy of the EOC or call **1-800-833-2364**.

Routine foot care
- In-network: **$45** copay for routine podiatry visits up to 6 visit(s) per year.
- Out-of-network: **$45** copay for routine podiatry visits up to 6 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 freshly made home delivered meal program for members with specific chronic conditions or special needs plans (SNP) and/or following an inpatient stay in the hospital or nursing facility. Meal delivery must be scheduled within 30 days of discharge event. Limited to four (4) times per year.
Prior authorization is required.

Over-the-Counter (OTC) mail order
$30 monthly allowance to buy approved over-the-counter health and wellness products available through our OTC Mail Order provider.

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

- The allowance is available to use on the 1st of every month.
- Limitations and restrictions may apply.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

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.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

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Notes

Notes

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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 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 .

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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。

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Find out **more**

Need help finding a doctor or pharmacy? You can see this plan's **Provider and Pharmacy Directory** at our website at **Humana.com/Find-Care** or call us at the number listed at the beginning of this booklet and we will send you one. Many doctor listings include a Care Highlight® rating. These ratings in clinical quality and cost-efficiency can help you make informed choices about your healthcare. Ratings only appear when we have enough information to measure a doctor's clinical quality and cost-efficiency. Learn more at **Humana.com/CareHighlight**.

You can see this 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.

Clinical quality and cost-efficiency ratings are available in all states except Alaska. Ratings are not available for all physicians. Care Highlight is intended for informational purposes only. Members have access to all physicians in the Humana network, regardless of whether or not the physician has a Care Highlight rating. Ratings should not be the sole basis for selecting a doctor. Humana does not give performance-based payments to doctors based on these ratings. Ratings do not guarantee the quality or outcome of healthcare services.

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 this plan may cover or other rules that may apply.

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

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More information is just a click away.

Visit **Humana.com/PlanDocuments** to see additional details about this plan, including benefits and costs.

If you'd like a printed Evidence of Coverage, Provider Directory, or Drug Guide 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 Guide" or "Provider Directory."

Activate your secure MyHumana account.

Your online MyHumana account is an important part of your Humana membership. Use it to view this plan's 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/Member/ManageYourAccount** and log in.

Don't have an account yet?

Create one using the same link above in just minutes.

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 any future calls using the Customer Care number on the back of your ID card.

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

Important information about this plan

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