

Summary of Benefits

Humana Gold Choice H8145-055 (PFFS)

Pennsylvania

Select counties in Pennsylvania

Our service area includes the following county/counties in Pennsylvania: Adams, Berks, Bradford, Carbon, Centre, Chester, Clinton, Cumberland, Dauphin, Erie, Franklin, Huntingdon, Juniata, Lackawanna, Lancaster, Lebanon, Luzerne, Lycoming, Mifflin, Perry, Susquehanna, Tioga, Wayne, Wyoming, York.

Pre-Enrollment Checklist

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

Understanding the Benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **Humana.com/medicare** or call **1-800-833-2364 (TTY: 711)** to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

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.
- 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.



Let's talk about Humana Gold Choice H8145-055 (PFFS)

Find out more about the Humana Gold Choice H8145-055 (PFFS) plan – including the health and drug services it covers – in this easy-to-use guide.

Humana Gold Choice H8145-055 (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](https://www.humana.com/PlanDocuments).

To be eligible

To join Humana Gold Choice H8145-055 (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 H8145-055 (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](https://www.humana.com/Medicare)

More about Humana Gold Choice H8145-055 (PFFS)

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 it's a good idea to select a doctor as your Primary Care Provider (PCP). Humana Gold Choice H8145-055 (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	\$0 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: <ul style="list-style-type: none"> • 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
Maximum out-of-pocket responsibility	\$6,700 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.	\$390 copay per day for days 1-5 \$0 copay per day for days 6-90	\$390 copay per day for days 1-5 \$0 copay per day for days 6-90
OUTPATIENT HOSPITAL COVERAGE		
Diagnostic colonoscopy	\$0 copay	\$0 copay
Diagnostic mammography	\$0 copay	\$0 copay
Surgery services	\$390 copay	\$390 copay
AMBULATORY SURGERY CENTER		
Diagnostic colonoscopy	\$0 copay	\$0 copay

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Medical Benefits (cont.)

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	IN-NETWORK	OUT-OF-NETWORK
Surgery services	\$340 copay	\$340 copay
DOCTOR VISITS		
Primary care provider (PCP)		
• PCP's office	\$10 copay	\$10 copay
• Telehealth	\$0 copay	Not Covered
Specialist		
• Specialist's office	\$30 copay	\$30 copay
• Telehealth	\$30 copay	Not Covered
PREVENTIVE CARE		
This plan covers all Medicare preventive services including:	\$0 copay	\$0 copay
<ul style="list-style-type: none"> • 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 		



Medical Benefits (cont.)

H8145055000

IN-NETWORK

OUT-OF-NETWORK

- 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

\$125 copay

\$125 copay

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

Physician and professional services at emergency room

\$0 copay

\$0 copay

URGENTLY NEEDED SERVICES

- Telehealth
- Urgent care center

\$55 copay

\$55 copay

Not Covered

\$55 copay

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

DIAGNOSTIC SERVICES, LABS AND IMAGING

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

- Freestanding radiological facility
- Outpatient hospital
- PCP's office
- Specialist's office

\$200 copay

\$325 copay

\$200 copay

\$200 copay

\$200 copay

\$325 copay

\$200 copay

\$200 copay

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Medical Benefits (cont.)

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	IN-NETWORK	OUT-OF-NETWORK
Basic radiological services (X-rays)		
• Freestanding radiological facility	\$50 copay	\$50 copay
• Outpatient hospital	\$130 copay	\$130 copay
• PCP's office	\$10 copay	\$10 copay
• Specialist's office	\$30 copay	\$30 copay
• Urgent care center	\$55 copay	\$55 copay
Diagnostic mammography		
• Freestanding radiological facility	\$0 copay	\$0 copay
• Specialist's office	\$30 copay	\$30 copay
Diagnostic procedures and tests		
• Outpatient hospital	\$105 copay	\$105 copay
• PCP's office	\$10 copay	\$10 copay
• Specialist's office	\$30 copay	\$30 copay
• Urgent care center	\$55 copay	\$55 copay
Lab services		
• Freestanding laboratory	\$30 copay	\$30 copay
• Outpatient hospital	\$50 copay	\$50 copay
• PCP's office	\$0 copay	\$0 copay
• Specialist's office	\$0 copay	\$0 copay
• Urgent care center	\$55 copay	\$55 copay
Nuclear medicine and services		
• Freestanding radiological facility	\$250 copay	\$250 copay
• Outpatient hospital	\$300 copay	\$300 copay
Sleep study		
• Member's home	\$0 copay	\$0 copay
• Outpatient hospital	\$105 copay	\$105 copay
• Specialist's office	\$105 copay	\$105 copay
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	\$30 copay	\$30 copay
HEARING SERVICES		
Medicare-covered hearing	\$30 copay	\$30 copay



	IN-NETWORK	OUT-OF-NETWORK
Mandatory supplemental hearing benefit	<p>HER937</p> <ul style="list-style-type: none"> • \$0 copay for routine hearing exams up to 1 per year. • \$699 copay for each Advanced level hearing aid up to 1 per ear per year. • \$999 copay for each Premium level hearing aid up to 1 per ear per year. <p>Hearing aid purchase includes:</p> <ul style="list-style-type: none"> • 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 <p>You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (TTY: 711).</p>	<p>The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.</p>

DENTAL SERVICES

Medicare-covered dental	\$30 copay	\$30 copay
<p>Mandatory supplemental dental benefit</p> <p>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</p>	<p>DEN350</p> <ul style="list-style-type: none"> • \$0 copay for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • \$0 copay for panoramic film or diagnostic x-rays up to 1 every 5 years. • \$0 copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • \$0 copay for emergency diagnostic exam up to 1 per year. 	<p>DEN350</p> <ul style="list-style-type: none"> • \$0 copay for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • \$0 copay for panoramic film or diagnostic x-rays up to 1 every 5 years. • \$0 copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • \$0 copay for emergency diagnostic exam up to 1 per year.



IN-NETWORK

OUT-OF-NETWORK

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. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement. The coinsurance level will apply to the average negotiated in-network fee schedule (INFS) in your area. See

- **\$0** copay for 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.

- **\$0** copay for periodic oral exam, prophylaxis (cleaning) up to 2 per year.
- **\$0** copay for periodontal maintenance up to 4 per year.
- **\$0** copay for necessary anesthesia with covered service up to unlimited per year.
- Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.



IN-NETWORK

OUT-OF-NETWORK

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	\$30 copay	\$30 copay

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



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.

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.
- OR
- **\$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.

MENTAL HEALTH SERVICES

Inpatient

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

\$390 copay per day for days 1-4
\$0 copay per day for days 5-90

\$390 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	\$95 copay	\$95 copay
• Partial hospitalization	\$55 copay	\$55 copay
• Specialist's office	\$40 copay	\$40 copay
Outpatient substance abuse services		
• Outpatient hospital	\$95 copay	\$95 copay
• Partial hospitalization	\$55 copay	\$55 copay
• Specialist's office	\$40 copay	\$40 copay
• Telehealth	\$40 copay	Not Covered
SKILLED NURSING FACILITY (SNF)		
This plan covers up to 100 days in a SNF	\$10 copay per day for days 1-20 \$214 copay per day for days 21-100	\$10 copay per day for days 1-20 \$214 copay per day for days 21-100
AMBULANCE		
	\$315 copay per date of service	\$315 copay per date of service
TRANSPORTATION		
	Not Covered	



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

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

	IN-NETWORK	OUT-OF-NETWORK
Acupuncture services (Medicare-covered)	\$30 copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.	\$30 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)	\$30 copay	\$30 copay
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	\$0 copay	20% of the cost
• Network retail pharmacy	10% of the cost	10% of the cost
• Preferred diabetic supplier	10% of the cost	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	\$20 copay	\$20 copay
• Outpatient hospital	\$40 copay	\$40 copay
• Specialist's office	\$20 copay	\$20 copay



Additional Benefits (cont.)

Physical therapy

- | | | |
|---|-------------------|-------------------|
| • Comprehensive outpatient rehab facility | \$20 copay | \$20 copay |
| • Outpatient hospital | \$40 copay | \$40 copay |
| • Specialist's office | \$20 copay | \$20 copay |

Pulmonary rehabilitation

- | | | |
|-----------------------|-------------------|-------------------|
| • Outpatient hospital | \$15 copay | \$15 copay |
| • Specialist's office | \$15 copay | \$15 copay |

Speech therapy

- | | | |
|---|-------------------|-------------------|
| • Comprehensive outpatient rehab facility | \$20 copay | \$20 copay |
| • Outpatient hospital | \$40 copay | \$40 copay |
| • Specialist's office | \$20 copay | \$20 copay |

Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD)

- | | | |
|-----------------------|-------------------|-------------------|
| • Outpatient hospital | \$15 copay | \$15 copay |
| • Specialist's office | \$15 copay | \$15 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 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.

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.

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

Humana.

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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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.

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