

Summary of Benefits

HumanaChoice R0110-016 (Regional PPO)

Ohio

Our service area includes the following state(s): Ohio.

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.



Let's talk about HumanaChoice R0110-016 (Regional PPO)

Find out more about the HumanaChoice R0110-016 (Regional PPO) plan – including the health and drug services it covers – in this easy-to-use guide.

HumanaChoice R0110-016 (Regional PPO) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, please refer to the plan's Evidence of Coverage on our website, [Humana.com/PlanDocuments](https://www.humana.com/PlanDocuments).

To be eligible

To join HumanaChoice R0110-016 (Regional PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name

HumanaChoice R0110-016 (Regional PPO)

How to reach us

If you're a member of this plan, call toll-free: **1-800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-833-2364 (TTY: 711)**.

October 1 - March 31:

Call 7 days a week from 8 a.m. – 8 p.m.

April 1 - September 30:

Call Monday - Friday, 8 a.m. – 8 p.m.

Or visit our website:

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

More about HumanaChoice R0110-016 (Regional PPO)

Do you have Medicare and Medicaid? If you are a dual-eligible beneficiary enrolled in both Medicare and your state Medicaid program, you may not have to pay the medical costs displayed in this booklet and your prescription drug costs may be lower, too.

If you have Medicaid, be sure to show your Medicaid ID card in addition to your Humana membership card to make your provider aware that you may have additional coverage. Your services are paid first by Humana and then by Medicaid.

As a member it's a good idea to select a doctor as your Primary Care Provider (PCP). HumanaChoice R0110-016 (Regional PPO) 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!

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Monthly Premium, Deductible and Limits

PLAN COSTS

Monthly plan premium	\$27 If you receive premium assistance, this plan premium may be reduced. You must keep paying your Medicare Part B premium.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	\$590 deductible
Maximum out-of-pocket responsibility	\$6,800 in-network \$10,000 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.	\$475 copay per day for days 1-5 \$0 copay per day for days 6-90	30% of the cost
OUTPATIENT HOSPITAL COVERAGE		
Diagnostic colonoscopy	\$0 copay	30% of the cost
Diagnostic mammography	\$0 copay	30% of the cost
Surgery services	\$475 copay	30% of the cost
AMBULATORY SURGERY CENTER		
Diagnostic colonoscopy	\$0 copay	30% of the cost
Surgery services	\$475 copay	30% of the cost
DOCTOR VISITS		
Primary care provider (PCP)		
• PCP's office	\$0 copay	30% of the cost
• Telehealth	\$0 copay	Not Covered

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from 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.)

R0110016000

	IN-NETWORK	OUT-OF-NETWORK
Specialist		
• Specialist's office	\$40 copay	30% of the cost
• Telehealth	\$40 copay	Not Covered
PREVENTIVE CARE		
This plan covers all Medicare preventive services including:	\$0 copay	\$0 copay or 30% of the cost, depending on the service and where service is provided
<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 • Routine physical exam • Sexually transmitted infections (STIs) screening and counseling 		

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Medical Benefits (cont.)

R0110016000

IN-NETWORK

OUT-OF-NETWORK

- **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

\$110 copay

\$110 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

\$0 copay

URGENTLY NEEDED SERVICES

- **Telehealth**
- **Urgent care center**

\$45 copay

\$45 copay

Not Covered

\$45 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

30% of the cost

30% of the cost

30% of the cost

30% of the cost

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Medical Benefits (cont.)

R0110016000

	IN-NETWORK	OUT-OF-NETWORK
Basic radiological services (X-rays)		
• Freestanding radiological facility	\$50 copay	30% of the cost
• Outpatient hospital	\$130 copay	30% of the cost
• PCP's office	\$0 copay	30% of the cost
• Specialist's office	\$50 copay	30% of the cost
• Urgent care center	\$55 copay	30% of the cost
Diagnostic mammography		
• Freestanding radiological facility	\$0 copay	30% of the cost
• Specialist's office	\$0 copay	30% of the cost
Diagnostic procedures and tests		
• Outpatient hospital	\$110 copay	30% of the cost
• PCP's office	\$0 copay	30% of the cost
• Specialist's office	\$40 copay	30% of the cost
• Urgent care center	\$55 copay	30% of the cost
Lab services		
• Freestanding laboratory	\$0 copay	30% of the cost
• Outpatient hospital	\$0 copay	30% of the cost
• PCP's office	\$0 copay	30% of the cost
• Specialist's office	\$0 copay	30% of the cost
• Urgent care center	\$55 copay	30% of the cost
Nuclear medicine and services		
• Freestanding radiological facility	\$180 copay	30% of the cost
• Outpatient hospital	\$350 copay	30% of the cost
Sleep study		
• Member's home	\$0 copay	30% of the cost
• Outpatient hospital	\$110 copay	30% of the cost
• Specialist's office	\$110 copay	30% of the cost
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	\$50 copay	20% of the cost

HEARING SERVICES

Medicare-covered hearing	\$40 copay	30% of the cost
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	IN-NETWORK	OUT-OF-NETWORK
Mandatory supplemental hearing benefit	<p>HER957</p> <ul style="list-style-type: none"> • \$0 copay for routine hearing exams up to 1 per year. • \$399 copay for each Standard level hearing aid up to 1 per ear 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 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	\$40 copay	30% of the cost
<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</p>	<p>DEN044</p> <ul style="list-style-type: none"> • \$0 copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • \$0 copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. 	<p>DEN044</p> <ul style="list-style-type: none"> • \$0 copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • \$0 copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years.

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IN-NETWORK

OUT-OF-NETWORK

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. 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

- **\$0** copay for bridge recementation, bridges-pontic, complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years.
- **\$0** copay for bridges-crown up to 2 every 5 years.
- **\$0** copay for crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime.
- **\$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.
- **\$0** copay for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year.
- **\$0** copay for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.
- **\$0** copay for periodontal maintenance up to 4 per year.
- **\$0** copay for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year.
- **\$2,500** combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.

- **\$0** copay for bridge recementation, bridges-pontic, complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years.
- **\$0** copay for bridges-crown up to 2 every 5 years.
- **\$0** copay for crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime.
- **\$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.
- **\$0** copay for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year.
- **\$0** copay for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.
- **\$0** copay for periodontal maintenance up to 4 per year.
- **\$0** copay for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year.
- **\$2,500** combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.

*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.)

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IN-NETWORK

OUT-OF-NETWORK

level will apply to the average negotiated in-network fee schedule (INFS) in your area. See Chapter 2 Payment Requests Contact Information in your Evidence of Coverage or visit **Humana.com** for information on requesting reimbursement.

When visiting an out-of-network provider there could be a difference between Humana's reimbursement and the dentist's charges. Members are responsible for this difference when visiting an out-of-network provider; this is known as balanced billing.

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

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

VISION SERVICES

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

\$0 copay

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

30% of the cost

Medicare-covered vision services **\$40** copay

30% of the cost

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

*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**.*



	IN-NETWORK	OUT-OF-NETWORK
<p>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.</p>	<p>VIS711</p> <ul style="list-style-type: none"> • \$0 copay for routine exam up to 1 per year. • \$40 combined maximum benefit coverage amount per year for routine exam. • \$300 maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • OR • \$350 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. <p>PLUS providers are part of the Humana Medicare Insight Network and are indicated in the provider locator search results.</p>	<p>VIS711</p> <ul style="list-style-type: none"> • \$0 copay for routine exam up to 1 per year. • \$40 combined maximum benefit coverage amount per year for routine exam. • \$300 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

\$475 copay per day for days 1-4
\$0 copay per day for days 5-90

30% of the cost

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from 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.)

R0110016000

	IN-NETWORK	OUT-OF-NETWORK
Mental health therapy visits		
• Outpatient hospital	\$95 copay	\$95 copay
• Partial hospitalization	\$55 copay	30% of the cost
• Specialist's office	\$40 copay	30% of the cost
Outpatient substance abuse services		
• Outpatient hospital	\$95 copay	\$95 copay
• Partial hospitalization	\$55 copay	30% of the cost
• Specialist's office	\$45 copay	30% of the cost
• Telehealth	\$40 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 \$214 copay per day for days 21-100	30% of the cost for days 1-100
AMBULANCE		
	\$300 copay per date of service	\$300 copay per date of service
TRANSPORTATION		
	Not Covered	

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from 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.)

	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	30% of the cost
• Specialist's office	20% of the cost	30% of the cost
Other Part B drugs		
• Outpatient hospital	20% of the cost	30% of the cost
• PCP's office	20% of the cost	30% of the cost
• Pharmacy	20% of the cost	30% of the cost
• Specialist's office	20% of the cost	30% of the cost
Part B Insulin		
• Outpatient hospital	20% of the cost	30% of the cost
• PCP's office	20% of the cost	30% of the cost
• Pharmacy	20% of the cost	30% of the cost
• Specialist's office	20% of the cost	30% 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

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

This plan has a **\$590** deductible. You pay the full cost of your drugs until you reach **\$590**. 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.

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.

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Pharmacy Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		Mail-Order Cost-Sharing	
	30-day	90-day*	30-day	90-day*
All Plan-Covered Part D Drugs	25%	25%	25%	25%

You have several options for filling your prescriptions, including retail and mail-order pharmacies. CenterWell Pharmacy® is the 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, even if you haven't paid your deductible.

Insulin Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		Mail-Order Cost-Sharing	
	30-day	90-day*	30-day	90-day*
All Plan-Covered Part D Insulins	\$35	\$105	\$35	\$105

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.

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)	\$40 copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.	\$40 copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Chiropractic services (Medicare-covered)	\$15 copay	30% of the cost
Podiatry services (Medicare-covered)	\$40 copay	30% of the cost
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

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Additional Benefits (cont.)

Diabetic monitoring supplies

• Diabetic supplier	20% of the cost	30% of the cost
• Network retail pharmacy	10% of the cost	30% of the cost
• Preferred diabetic supplier	\$0 copay	Not Covered

Durable medical equipment (DME)

20% of the cost	20% of the cost
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Medical supplies at medical supplier

20% of the cost	30% of the cost
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Prosthetics devices and related supplies at prosthetics provider

20% of the cost	30% of the cost
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REHABILITATION SERVICES

Cardiac rehabilitation services

• Outpatient hospital	\$15 copay	30% of the cost
• Specialist's office	\$15 copay	30% of the cost

Occupational therapy

• Comprehensive outpatient rehab facility	\$15 copay	30% of the cost
• Outpatient hospital	\$35 copay	30% of the cost
• Specialist's office	\$15 copay	30% of the cost

Physical therapy

• Comprehensive outpatient rehab facility	\$15 copay	30% of the cost
• Outpatient hospital	\$35 copay	30% of the cost
• Specialist's office	\$15 copay	30% of the cost

Pulmonary rehabilitation

• Outpatient hospital	\$15 copay	30% of the cost
• Specialist's office	\$15 copay	30% of the cost

Speech therapy

• Comprehensive outpatient rehab facility	\$15 copay	30% of the cost
• Outpatient hospital	\$35 copay	30% of the cost
• Specialist's office	\$15 copay	30% of the cost

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

• Outpatient hospital	\$15 copay	30% of the cost
• Specialist's office	\$15 copay	30% of the cost



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**.

Travel Coverage

The PPO national network gives you in-network coverage across the country, so you can see any doctor who accepts the plan terms and conditions. You'll be able to travel with ease or split your time between locations. Visit [Humana.com](https://www.humana.com) or contact Customer Care on the back of your ID card if you need help finding an in-network provider.

Routine foot care

- In-network: **\$40** copay for routine podiatry visits up to 6 visit(s) per year.
- Out-of-network: **\$40** 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 meal program for members with certain special needs plan (SNP) specific conditions 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

\$100 quarterly allowance to buy approved over-the-counter health and wellness products available through our OTC Mail Order provider.

Unused amount expires at the end of the quarter.

- Quarterly allowance amounts are available to use at the beginning of January, April, July, and October.
- 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.

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。



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.

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

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More information is just a click away.

Visit [Humana.com/PlanDocuments](https://www.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](https://www.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.

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

Important information about this plan

[Humana.com](https://www.humana.com)