2019

Summary of Benefits

Humana Gold Plus® SNP-DE H3533-002 (HMO SNP)

Upstate New York
Select Counties in New York

Our service area includes the following county/counties in New York: Albany, Broome, Chemung, Oneida, Onondaga, Oswego, Rensselaer, Saratoga, Schenectady, Steuben, Tioga, Warren, Washington.

Humana®

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

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. 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.

Understanding Important Rules

- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2020.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. This plan may enroll dual eligibles who are QMB Plus, QMB and FBDE.

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Humana®

Let's talk about Humana Gold Plus SNP-DE H3533-002 (HMO SNP)

Find out more about the Humana Gold Plus SNP-DE H3533-002 (HMO SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus SNP-DE H3533-002 (HMO SNP) is a Coordinated Care plan with a Medicare contract and a contract with the New York State Department of Health (SDOH) Medicaid Program. 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, ask us for the "Evidence of Coverage" or you will receive one after you enroll.

As a member you must select an in-network doctor to act as your Primary Care Provider (PCP). Humana Gold Plus SNP-DE H3533-002 (HMO SNP) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services. You have access to Care Managers. Care Managers are nurses or care coordinators who support your health and well-being by providing additional services including: acute and chronic-care management, telephonic and in-person health support; assistance in coordinating Medicare and Medicaid benefits, educational resources and workshops and support for families and caregivers.

To be eligible

To enroll in Humana Gold Plus SNP-DE H3533-002 (HMO SNP), a Dual Eligible Special Needs Plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B, live in our service area and also receive certain levels of assistance from the New York Medical Assistance program (Medicaid). If you receive both Medicare and Medicaid benefits, this means you are a dual eligible.

Humana Gold Plus SNP-DE H3533-002 (HMO SNP) may enroll dual eligibles who are QMB Plus, QMB and FBDE.

Plan name:

Humana Gold Plus SNP-DE H3533-002 (HMO SNP)

More about Humana Gold Plus SNP-DE H3533-002 (HMO SNP)

As a member of this plan, you will not be responsible for cost sharing for plan benefits. The Comprehensive Benefit Chart shows the benefits you will receive from Humana and how Medicaid covers your cost sharing for those plan benefits. The chart also lists some benefits you could receive from Medicaid if you are eligible for full Medicaid benefits. If you are entitled to Medicaid benefits your care coordinator will work with you to assist you in understanding and accessing the Medicare and Medicaid benefits you may be entitled to.
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.

How to reach us:

If you have questions about your benefits or your level of eligibility for assistance from Medicaid, you should contact Humana's Customer Care department or your state Medicaid office for further details.

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**.

For the most current New York Medicaid coverage information, please visit the New York Medicaid website at http://www.health.ny.gov/health_care/medicaid/ or call the Medicaid Hotline at **1-800-541-2831 (TTY: 711)**.

A healthy partnership

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

Monthly Premium, Deductible and Limits

Monthly plan premium	**$0** You must keep paying your Medicare Part B premium. The Part B premium may be covered through your State Medicaid Program.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	This plan does not have a deductible.
Maximum out-of-pocket responsibility	This plan does not have a maximum out-of-pocket responsibility.

Covered Medical and Hospital Benefits

For members protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copays and deductibles for Original Medicare covered services.

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
ACUTE INPATIENT HOSPITAL CARE		
	$0 copay	
OUTPATIENT HOSPITAL COVERAGE		
Outpatient surgery at outpatient hospital	**$0** copay	
Outpatient surgery at ambulatory surgical center	**$0** copay	
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	
Specialists	**$0** copay	
PREVENTIVE CARE		
	Our plan covers many preventive services at no cost when you see an in-network provider including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings	

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

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
	• Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including flu shots, hepatitis B shots, pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Annual Wellness Visit • Lung cancer screening • Routine physical exam • Medicare diabetes prevention program **Any additional preventive services approved by Medicare during the contract year will be covered.**	
EMERGENCY CARE		
Emergency room If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	**$0** copay	

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

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$0** copay	
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic Mammography	**$0** copay	
Diagnostic radiology	**$0** copay	
Lab services	**$0** copay	
Diagnostic tests and procedures	**$0** copay	
Outpatient X-rays	**$0** copay	
Radiation Therapy	**$0** copay	
HEARING SERVICES		
Medicare covered hearing	**$0** copay	• Medicaid hearing services and products when medically necessary to alleviate disability caused by the loss or impairment of hearing. • Services include hearing aid selecting, fitting, and dispensing; hearing aid checks following dispensing, conformity evaluations and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aid prescriptions.
Routine hearing HER945	• **$0** copayment for routine hearing exams up to 1 per year. • **$0** copayment for fitting/evaluation up to 3 per year. • **$0** copayment for advanced level hearing aid purchase up to 1 per ear per year. • Note: Includes 48 batteries per aid and 3 year warranty. TruHearing provider must be used.	

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

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
DENTAL SERVICES The cost-share indicated below is what you pay for the covered service.		
Medicare covered dental	**$0** copay	• Dental services include, but shall not be limited to necessary preventive, prophylactic and other routine dental care, services and supplies and dental prosthetics to alleviate a serious health condition. • Ambulatory or inpatient surgical dental services subject to prior authorization.
Routine dental DEN115 Use the HumanaDental Medicare network for the Mandatory Supplemental Dental. The provider locator can be found at Humana.com > Find a Doctor > from the Search Type drop down select Dental > under Coverage Type select All Dental Networks > enter zip code > from the network drop down select HumanaDental Medicare.	• **$0** copayment for periodontal exam up to 1 every 3 years. • **$0** copayment for complete dentures, partial dentures up to 1 set(s) every 5 years. • **$0** copayment for panoramic film or diagnostic x-rays up to 1 every 5 years. • **$0** copayment for bitewing x-rays up to 1 set(s) per year. • **$0** copayment for adjustments to dentures, crown, denture reline, intraoral x-rays up to 1 per year. • **$0** copayment for amalgam and/or composite filling, periodic oral exam, and/or comprehensive oral evaluation, prophylaxis (cleaning), simple or surgical extraction up to 2 per year. • **$0** copayment for necessary anesthesia with covered service up to unlimited per year. • **$1000** combined maximum benefit coverage amount per year.	

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

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
VISION SERVICES		
Medicare covered vision services	**$0** copay	• Services of optometrists, ophthalmologists and ophthalmic dispensers. • Coverage also includes examinations for diagnosis and treatment for visual defects and/or eye disease. • Examinations for refraction are limited to every two (2) years unless otherwise justified as medically necessary.
Diabetic eye exam	**$0** copay	
Glaucoma screening	**$0** copay	
Eyewear (post-cataract)	**$0** copay	
Routine vision VIS733 The provider locator can be found at Humana.com > Find a Doctor > from the Search Type drop down select Vision > Eyemed Select Network.	• **$0** copayment for routine exam, refraction up to 1 per year. • **$300** maximum benefit coverage amount per year for contact lenses or eyeglasses - lenses and frames (includes fitting). Eyeglasses will include ultraviolet protection and scratch resistant coating.	
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$0** copay	
Outpatient group and individual therapy visits	**$0** copay	
SKILLED NURSING FACILITY (SNF)		
Your plan covers up to 100 days in a SNF	**$0** copay	
PHYSICAL THERAPY		
	$0 copay	
AMBULANCE		
Ambulance (ground)	**$0** copay	
TRANSPORTATION		
	$0 copay for up to 48 one-way trips to plan approved locations. Not to exceed 50 miles per trip. The member *must* contact transportation vendor to arrange transportation.	

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

Prescription Drug Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
MEDICARE PART B DRUGS		
Chemotherapy drugs	**$0** copay	
Other part B drugs	**$0** copay	
PRESCRIPTION DRUGS		
Medicare Part D Drugs	See chart below for plan coverage information for prescription drugs	Medicaid may cover some drugs that are not covered by Part D. Contact your Medicaid agency for questions on drug coverage. • Medicaid covers Medicaid prescription drugs not covered by a Medicare Prescription Drug Plan. • Copays: – **$3** Brand – **$1** Generic – **$0.50** OTC

Deductible This plan does not have a deductible.

Depending on the level of Extra Help you receive, you'll pay one of the following cost-share amounts each time you fill your drug. You will always pay **$0** for Tier 1 drugs on this plan at a Preferred Cost-Sharing Retail or Preferred Cost-Sharing Mail Order Pharmacy.

Pharmacy options		
Preferred cost-sharing	**Mail order:** Humana Pharmacy® **Retail:** To find the preferred cost-share retail pharmacies near you, go to **Humana.com/pharmacyfinder**	
Standard cost-sharing	**Mail order:** Walmart Mail **Retail:** All other network retail pharmacies	
For generic drugs (including brand drugs treated as generic), either:	**30-day supply** **$0** copay; or **$1.25** copay; or **$3.40** copay;	**90-day supply** **$0** copay; or **$1.25** copay; or **$3.40** copay;
For all other drugs, either:	**$0** copay; or **$3.80** copay; or **$8.50** copay;	**$0** copay; or **$3.80** copay; or **$8.50** copay;

Specialty drugs are limited to a 30 day supply.

Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 Monday — Friday, 7 a.m. — 7 p.m. TTY users should call 1-800-325-0778. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our "Evidence of Coverage" online.

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

You may get drugs from an out-of-network pharmacy but may pay more than you pay at an in-network pharmacy.

Days' Supply Available
Unless otherwise specified, you can get your Part D drug in the following days' supply amounts:
- One month supply (up to 30 days)*
- Two month supply (31-60 days)
- Three month supply (61-90 days)

*Long term care pharmacy (one month supply = 31 days)

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$5,100**, you pay nothing for all drugs.

Additional benefits

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
Medicare-covered foot care (podiatry)	**$0** copay	
Medicare-covered chiropractic services	**$0** copay	
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**$0** copay	Non-Medicare covered DME
Medical Supplies	**$0** copay	
Prosthetics (artificial limbs or braces)	**$0** copay	
Diabetic monitoring supplies	**$0** copay	
REHABILITATION SERVICES		
Physical, occupational and speech therapy	**$0** copay	
Cardiac rehabilitation	**$0** copay	
Pulmonary rehabilitation	**$0** copay	

Additional Medicaid Covered Services

Dual eligible members who meet financial criteria for full Medicaid coverage may also be eligible to receive all Medicaid services not covered by Medicare. Humana Gold Plus may also offer coverage for these services. The benefits described below are covered by Medicaid. The benefits described in the Covered Medical and Hospital Benefits section of the Summary of Benefits are covered by Medicare. For each benefit listed below, you can see what the New York State Department of Health (SDOH) Medicaid Program covers and what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility. If you have questions about your Medicaid eligibility and what benefits you are entitled to call: 1-800-541-2831 (TTY: 711).

BENEFIT	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID STATE PLAN
PRODUCTS AND DEVICES		
Dentures	See "Dental" benefit in the "Covered Medical and Hospital Benefits" chart above	Not covered.
Eyeglasses	See "Vision" benefit in the "Covered Medical and Hospital Benefits" chart above	• Services of optometrists, ophthalmologists and ophthalmic dispensers including eyeglasses, medically necessary contact lenses and poly-carbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Coverage also includes the repair or replacement of parts. • Eyeglasses do not require changing more frequently than every two (2) years unless medically necessary or unless the glasses are lost, damaged or destroyed.
Hearing Aids	See "Hearing" benefit in the "Covered Medical and Hospital Benefits" chart above	• Covers hearing aid products including hearing aids, ear molds, special fittings and replacement parts.

TRANSPORTATION		
Non-Emergency Medical Transportation Services	See "Transportation" benefit in the "Covered Medical and Hospital Benefits" chart above	• Transportation expenses are covered when transportation is essential in order for a Member to obtain necessary medical care and services under the Medicaid program. Transportation services means transportation by ambulance, ambulette, fixed wing or airplane transport, invalid coach, taxicab, livery, public transportation, or other means appropriate to the enrollee's medical condition and a transportation attendant to accompany the enrollee, if necessary.
INPATIENT LONG TERM CARE SERVICES		
Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services in Institutions for Mental Diseases (IMD), age 65 and older	Not covered	• Covered. • Inpatient mental health over 190-Day Lifetime limit.
Inpatient Psychiatric Services, under age 21	See "Mental Health" benefit in the "Covered Medical and Hospital Benefits" chart above	Covered
Intermediate Care Facility Services for Individuals with Intellectual Disabilities	Not Covered	Covered
Nursing Facility Services, other than in an Institution for Mental Diseases	See "Skilled Nursing" benefit in the "Covered Medical and Hospital Benefits" chart above	• Covered. • Skilled nursing facility days provided by a licensed facility in excess of the first 100 days in the Medicare Advantage benefit period. • Institutional Medicaid coverage for permanent placement is required.
COMMUNITY BASED LONG TERM CARE AND MENTAL HEALTH SERVICES		
Personal Care Services	Not Covered	Services such as housekeeping, meal preparation, bathing, toileting, and grooming.

Certain Mental Health Services including:	Not Covered	• Intensive Psychiatric Rehabilitation Treatment Programs. • Day Treatment. • Continuing Day Treatment. • Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units). • Partial Hospitalizations Assertive Community - Treatment (ACT). • Personalized Recovery Oriented Services (PROS).
Medical Social Services	Not Covered.	• Service to assess the need for, arranging for and providing aid for social problems related to the maintenance of a patient in the home. • Services must be provided by a qualified social worker and provided within a plan of care.
Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs	Not Covered	Covered
Comprehensive Medicaid Case Management	Not Covered	Covered
Adult Day Health Care	Not Covered	• ADHC's provide a comprehensive range of services in a community-based, non-institutional setting. General medical care, including treatment adherence support, nursing care, nutritional services, case management, HIV risk reduction, substance abuse, mental health and rehabilitative services are among those provided.
Personal Emergency Response System	Not Covered	An electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency.

OTHER MEDICAID COVERED SERVICES		
Over-the-Counter (OTC) benefits	See “Over-the-Counter benefits” benefit on the “More benefits with your plan” page later in this document	Certain OTC drugs are covered.

HOME AND COMMUNITY BASED WAIVER SERVICES
Dual eligible members, who meet the financial criteria for full Medicaid coverage, may also be eligible to receive Waiver services. Waiver services are limited to individuals who meet additional waiver eligibility criteria. For information on waiver services and eligibility, contact Medicaid at 1-800-541-2831 (TTY: 711).

The Additional Medicaid Covered Services table above reflects Medicaid services available on a fee for service basis for dual eligibles who meet the eligibility requirements for full Medicaid benefits.

The Medicaid information included in this section is current as of 7/1/2018. All Medicaid covered services are subject to change at any time. For the most current New York Medicaid coverage information, please visit the New York Medicaid website at http://www.health.ny.gov/health_care/medicaid/ or call the Medicaid Hotline at **1-800-541-2831 (TTY: 711)**.

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

Smoking cessation program
To further assist in your effort to quit smoking or tobacco product use, we cover one additional counseling quit attempt within a 12-month period as a service with no cost to you. This is in addition to the two counseling attempt provided by Medicare and includes up to four face-to-face visits. This service can be used for either preventive measures or for diagnosis with a tobacco related disease.

Enhanced Nutrition Therapy
Additional one-on-one nutrition therapy counseling.

Well Dine Meal Program
Humana's meal program for members following an inpatient stay in the hospital or nursing facility

HumanaFirst® Nurse Hotline
Health advice from a registered nurse, available 24 hours a day, seven days a week.

Over-the-Counter (OTC) card
Up to **$130** allowance per month over-the-counter (OTC) card to purchase eligible OTC health and wellness products at participating retailers.

Personal Emergency Response System
This provides you help in emergency situations. The medical alert service comes with an installed in-home communication device and a wearable button to call for help when you've fallen at home or have an emergency.

Virtual Visits - Medical
Access to doctors and other practitioners via phone and/or video technology for diagnosis and treatment of certain non-emergency medical issues.

You pay a **$0** copay to receive a remote medical consultation.

Virtual Visits – Mental and Behavioral Health
Access to doctors and other mental health professionals via phone and/or video technology for diagnosis and treatment of certain non-emergency mental or behavioral issues.

You pay a **$0** copay to receive a remote mental and behavioral consultation.

Wigs (related to chemotherapy treatment)
Up to a **$500** maximum benefit per year.

Go365™ by Humana
Rewards for completing certain preventive health screenings and health and wellness activities.

SilverSneakers® fitness program
Basic fitness center membership including fitness classes.

Find out **more**

You can see our plan's **provider and pharmacy directory** at our website at **www.humana.com/members/tools** or call us at the number listed at the beginning of this booklet and we will send you one.

You can see our plan's **drug list** at our website at **www.humana.com/medicare/medicare_prescription_drugs/medicare_drug_tools/medicare_drug_list/** or call us at the number listed at the beginning of this booklet and we will send you one.

This information is not a complete description of benefits. Call 1-800-457-4708 (TTY: 711) for more information.

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.

This information is available in a different format, including Braille, large print, and audio tapes. Please call Customer Care at the number listed in the beginning of this document if you need plan information in another format.
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-833-2364 (TTY: 711).

Humana has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2020 based on a review of Humana's Model of Care.

The provider/pharmacy network may change at any time. You will receive notice when necessary.

Limitations on healthcare and prescription services delivered via virtual visits and communications options vary by state. Virtual visit services are not a substitute for emergency care and not intended to replace your primary care provider or other providers in your network. This material is provided for informational use only and should not be construed as medical advice or used in place of consulting a licensed medical professional.

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Notes

Notes

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion.

Humana Inc. and its subsidiaries provide: (1) free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate; and, (2) free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call **1-877-320-1235** or if you use a **TTY**, call **711**.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion, you can file a grievance with Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.

If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through 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, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Multi-Language Interpreter Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-877-320-1235 **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-1235 **(TTY: 711)** 注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。 請致電 1-877-320-1235 **(TTY : 711)**。 ... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-320-1235 **(TTY: 711)**.... 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-877-320-1235 **(TTY: 711)** 번으로 전화해 주십시오 .... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-320-1235 **(TTY: 711)**.... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-320-1235 **(телетайп: 711)**.... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-320-1235 **(TTY: 711)**.... ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-320-1235 **(ATS: 711)**.... UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-320-1235 **(TTY: 711)**.... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-320-1235 **(TTY: 711)**.... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-320-1235 **(TTY: 711)**.... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-320-1235 **(TTY: 711)**.... 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-877-320-1235 **(TTY: 711)** まで、お電話にてご連絡ください。...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-320-1235 تماس بگیرید. **(TTY: 711)**

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-877-320-1235 **(TTY: 711)**....

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-320-1235 **(رقم هاتف الصم والبكم: 711)**.

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