2019

Summary of Benefits

Optional Supplemental Benefits

Humana Gold Choice® H8145-123 (PFFS)

Colorado, New Mexico
Select Counties in Colorado and New Mexico

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

- ☐ 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 copayments/co-insurance may change on January 1, 2020.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you may pay a higher co-pay for services received by non-contracted providers.

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Colorado, New Mexico
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Our service area includes the following county/counties in Colorado: Adams, Arapahoe, Boulder, Broomfield, Chaffee, Costilla, Crowley, Custer, Delta, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Grand, Huerfano, Jefferson, Larimer, Mesa, Montrose, Morgan, Otero, Park, Pueblo, Weld
New Mexico: Bernalillo, Colfax, Dona Ana, Grant, Lincoln, Luna, Otero, Rio Arriba, San Miguel, Sandoval, Santa Fe, Sierra, Taos, Torrance, Valencia.

Let's talk about Humana Gold Choice H8145-123 (PFFS)

Find out more about the Humana Gold Choice H8145-123 (PFFS) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Choice H8145-123 (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, ask us for the "Evidence of Coverage" or you will receive one after you enroll.

To be eligible

To join Humana Gold Choice H8145-123 (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 H8145-123 (PFFS)

How to reach us:

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

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

October 1 - March 31:
Call 7 days a week from 8 a.m. - 8 p.m.

April 1 - September 30:
Call Monday - Friday, 8 a.m. - 8 p.m.

Or visit our website:
Humana.com/medicare.

More about Humana Gold Choice H8145-123 (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 and your prescription drug costs will be lower, too.

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

As a member it's a good idea to select a doctor as your Primary Care Provider (PCP). Humana Gold Choice H8145-123 (PFFS) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, you may be subject to higher copayments/coinsurance.

A healthy partnership

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

Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
PLAN COSTS		
Monthly plan premium You must keep paying your Medicare Part B premium.	**$103**	
Medical deductible	This plan does not have a deductible.	
Pharmacy (Part D) deductible	**$300** for Tier 3, Tier 4, Tier 5.	
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for medical services for the year.	**$6,700** combined in- and out-of-network	**$6,700** combined in- and out-of-network

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
	$325 copay per day for days 1-5 **$0** copay per day for days 6-90 Your plan covers an unlimited number of days for an inpatient stay.	**$325** copay per day for days 1-5 **$0** copay per day for days 6-90
OUTPATIENT HOSPITAL COVERAGE		
Outpatient surgery at outpatient hospital	**$325** copay	**$325** copay
Outpatient surgery at ambulatory surgical center	**$275** copay	**$275** copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$15** copay	**$15** copay
Specialists	**$50** copay	**$50** 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	**$0** copay

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
	• Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • 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	**$90** copay	**$90** copay

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$30** copay at a preferred urgent care center **$40** copay at a non-preferred urgent care center	**$40** copay at an urgent care center
OUTPATIENT CARE AND DIAGNOSTIC SERVICES, LABS AND IMAGING Cost share may vary depending on the service and where service is provided		
Diagnostic Mammography	**$50** to **$80** copay	**$50** to **$80** copay
Diagnostic radiology	**$180** to **$325** copay	**$180** to **$325** copay
Lab services	**$0** to **$45** copay	**$0** to **$45** copay
Diagnostic tests and procedures	**$0** to **$100** copay	**$0** to **$100** copay
Outpatient X-rays	**$15** to **$100** copay	**$15** to **$100** copay
Radiation Therapy	**$50** or **20%** of the cost	**$50** or **25%** of the cost
HEARING SERVICES		
Medicare covered hearing	**$50** copay	**$50** copay
Routine hearing HER941	• **$0** copayment for routine hearing exams up to 1 per year. • **$0** copayment for fitting/evaluation up to 3 per year. • **$699** copayment for advanced level hearing aid up to 1 per ear per year. • **$999** copayment for premium hearing aid purchase up to 1 per ear per year. • Note: Includes 48 batteries per aid and 3 year warranty.	• **$0** copayment for routine hearing exams up to 1 per year. • **$0** copayment for fitting/evaluation up to 3 per year. • **$699** copayment for advanced level hearing aid up to 1 per ear per year. • **$999** copayment for premium 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 for in and out-of-network hearing aid benefit. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
DENTAL SERVICES The cost-share indicated below is what you pay for the covered service. Additional dental benefits are available with a separate monthly premium. Please see the "Optional Supplemental Benefits" page for details.		
Medicare covered dental	**$50** copay	**$50** copay

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Routine dental DEN767 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%** coinsurance for bitewing x-rays up to 1 set(s) per year. • **0%** coinsurance for periodic oral exam or comprehensive oral evaluation, prophylaxis (cleaning) up to 1 per year. • **0%** coinsurance for necessary anesthesia with covered service up to unlimited per year. • **50%** coinsurance for amalgam or composite filling up to 1 per year. • **$1000** combined maximum benefit coverage amount per year for amalgam or composite filling, bitewing x-rays, necessary anesthesia with covered service, periodic oral exam or comprehensive oral evaluation, prophylaxis (cleaning).	• **50%** coinsurance for bitewing x-rays up to 1 set(s) per year. • **50%** coinsurance for periodic oral exam or comprehensive oral evaluation, prophylaxis (cleaning) up to 1 per year. • **50%** coinsurance for necessary anesthesia with covered service up to unlimited per year. • **55%** coinsurance for amalgam or composite filling up to 1 per year. • **$1000** combined maximum benefit coverage amount per year for amalgam or composite filling, bitewing x-rays, necessary anesthesia with covered service, periodic oral exam or comprehensive oral evaluation, prophylaxis (cleaning). • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
VISION SERVICES		
Medicare covered vision services	**$50** copay	**$50** copay
Diabetic Eye Exam	**$0** copay	**$50** copay
Glaucoma screening	**$0** copay	**$0** copay
Eyewear (post-cataract)	**$25** copay	**$25** copay
Routine vision VIS776 The provider locator can be found at Humana.com > Find a Doctor > from the Search Type drop down select Vision > Eyemed Select Network.	• **$130** maximum benefit coverage amount per year for routine exam, refraction up to 1 per year.	• **$130** maximum benefit coverage amount per year for routine exam, refraction up to 1 per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$325** copay per day for days 1-4 **$0** copay per day for days 5-90	**$325** copay per day for days 1-4 **$0** copay per day for days 5-90
Outpatient group and individual therapy visits	**$20** copay	**$20** copay
SKILLED NURSING FACILITY (SNF)		
Your plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$172** copay per day for days 21-60 **$0** copay per day for days 61-100	**$0** copay per day for days 1-20 **$172** copay per day for days 21-60 **$0** copay per day for days 61-100
PHYSICAL THERAPY		
	$30 copay	**$30** copay
AMBULANCE		
Ambulance (ground)	**$265** per date of service	**$265** per date of service
TRANSPORTATION		
	Not covered	Not covered

Prescription Drug Benefits

MEDICARE PART B DRUGS		
Chemotherapy drugs	**20%** of the cost	**25%** of the cost
Other part B drugs	**20%** of the cost	**25%** of the cost
PRESCRIPTION DRUGS		

Deductible This plan has a **$300** deductible for Tier 3, Tier 4, Tier 5 drugs. You pay the full cost of these drugs until you reach $300. Then, you only pay your cost-share.

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach **$3,820**. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.

Preferred cost-sharing				
Pharmacy options	**Retail** To find the preferred cost-share retail pharmacies near you, go to **Humana.com/pharmacyfinder**		**Mail order** Humana Pharmacy®	
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 1: Preferred Generic	$7	$21	$7	$0
Tier 2: Generic	$15	$45	$15	$0
Tier 3: Preferred Brand	$47	$141	$47	$131
Tier 4: Non-Preferred Drug	$100	$300	$100	$290
Tier 5: Specialty Tier	27%	N/A	27%	N/A
Standard cost-sharing				
Pharmacy options	**Retail** All other network retail pharmacies.		**Mail order** Walmart Mail	
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 1: Preferred Generic	$10	$30	$10	$30
Tier 2: Generic	$20	$60	$20	$60
Tier 3: Preferred Brand	$47	$141	$47	$141
Tier 4: Non-Preferred Drug	$100	$300	$100	$300
Tier 5: Specialty Tier	27%	N/A	27%	N/A

Generic drugs may be covered on tiers other than Tier 1 and Tier 2 so please check this plan's Humana Drug List to validate the specific tier on which your drugs are covered.

Specialty drugs are limited to a 30 day supply.

Certain drugs may need advance approval before your plan will cover any of the costs. This is called "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.

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)

Coverage Gap

After you enter the coverage gap, you pay **25 percent** of the plan's cost for covered brand name drugs and **37 percent** of the plan's cost for covered generic drugs until your costs total **$5,100** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

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 the greater of:
- **5%** of the cost, or
- **$3.40** copay for generic (including brand drugs treated as generic) and a **$8.50** copayment for all other drugs

Additional benefits

	IN-NETWORK	OUT-OF-NETWORK
Medicare-covered foot care (podiatry)	**$50** copay	**$50** copay
Medicare-covered chiropractic services	**$20** copay	**$40** copay
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**20%** of the cost	**25%** of the cost
Medical Supplies	**20%** of the cost	**25%** of the cost
Prosthetics (artificial limbs or braces)	**20%** of the cost	**25%** of the cost
Diabetic monitoring supplies Cost share may vary depending on where service is provided.	**$0** copay or **10%** to **20%** of the cost	**25%** of the cost
REHABILITATION SERVICES		
Physical, occupational and speech therapy	**$30** copay	**$30** copay
Cardiac rehabilitation	**$30** copay	**$30** copay
Pulmonary rehabilitation	**$30** copay	**$30** copay

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

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) mail order
Up to **$25** allowance every 3 months for the purchase of OTC supplies from Humana Pharmacy mail delivery.

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.

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

Optional **Supplemental Benefits**

Customize your coverage for an extra monthly premium when you enroll. You can choose from the following to help create your Medicare plan.

$25.10

MyOption Enhanced Dental DEN840
Enhances the dental coverage already included in your Medicare Advantage plan with additional benefits for preventive, basic, and major services at both in-network (HumanaDental Medicare network) and out-of-network dentists. These extra benefits – in addition to your basic benefits – have an additional monthly premium.

$15

MyOption Fitness
A basic fitness membership at any SilverSneakers® participating location in the country. Members have access to locations across the nation.

Humana MyOption optional supplemental benefits (OSB) are only available to members of certain Humana Medicare Advantage (MA) plans. Members of Humana plans that offer OSBs may enroll in OSBs throughout the year. Benefits may change on January 1 each year. Enrollees must use network providers for specific OSBs when stated in the Evidence of Coverage (EOC); otherwise, covered services may be received from non-network providers at a higher cost. Enrollees must continue to pay the Medicare Part B premium, their Humana plan premium and the OSB premium.

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).

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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2019

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H8145-123 (PFFS)

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Humana®

My Options, My Choice
Adding Benefits to Your Plan

You're unique and have unique needs. That's why Humana offers optional supplemental benefits (OSB). For an extra monthly premium you can customize your Humana Medicare Advantage plan.

You can add these extra benefits when you sign up for your Medicare Advantage plan or any time during the year.

The information in this booklet will tell you about the benefits you can add to your plan. If you have questions, you can call us at 1-888-866-3154 (TTY: 711). We are available seven days a week, from 8 a.m. - 8 p.m. local time. However, please note that our automated phone system may answer your call during weekends and holidays from April 1 - September 30. Please leave your name and telephone number, and we will call you back by the end of the next business day.

MyOption℠ Enhanced Dental (DEN840)

The MyOption℠ Enhanced Dental benefit helps make it easy for you to plan for your dental care.

Here's how the benefit works:

Monthly Premium	**$25.10**		
Maximum Benefit	Humana pays up to **$2,000** per calendar year		
Covered Dental Services	**In-Network* You Pay**	**Out-Of-Network** You Pay**	**Benefit Limitations Per Calendar Year**
Preventive and Diagnostic Dental Services			
Oral examinations	**0%**	**50%**	Two per year
Periodontal exam	**0%**	**50%**	One procedure every three years
Dental prophylaxis (cleanings)	**0%**	**50%**	Two per year
Fluoride treatment	**0%**	**50%**	Two per year
Bitewing X-ray	**0%**	**50%**	One set per year
Intraoral X-ray	**0%**	**50%**	One set per year
Panoramic or diagnostic X-rays	**0%**	**50%**	One set every five years
Basic Dental Services (Minor Restorative)			
Amalgam restorations (silver fillings)	**50%**	**55%**	Two per year
Composite resin restorations (white fillings)	**50%**	**55%**	
Extractions (pulling teeth), simple or surgical	**50%**	**55%**	Two per year

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations Per Calendar Year
Basic Dental Services (Minor Restorative)			
Recementation	**50%**	**55%**	One procedure every five years
Emergency treatment for pain	**50%**	**55%**	Two per year
Anesthesia	**0%**	**50%**	Unlimited per calendar year
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Periodontal maintenance	**70%**	**75%**	Two per year
Crowns	**70%**	**75%**	Two per year
Periodontal scaling and root planing (deep cleaning)	**70%**	**75%**	One procedure for each quadrant every three years

Covered dental services are subject to conditions, limitations, exclusions, and maximums. Please see your Evidence of Coverage for details.

*Network dentists have agreed to provide services at an in-network rate. If you see a network dentist, you can't be billed more than the in-network rate.

**If you use an out-of-network dentist, your share of the cost may be higher.

The Humana Optional Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at Humana.com > Find a Doctor > from the Search Type drop down select Dental > HumanaDental Medicare.

MyOption℠ Fitness

The MyOption℠ Fitness benefit helps you pay for your fitness needs. This benefit covers the cost of a basic membership at any SilverSneakers® fitness center anywhere in the country.

You can reach your health, wellness, and fitness goals with SilverSneakers classes. The monthly premium for this OSB is **$15**. Here's how the benefit works:

Covered services
- Fitness center membership at any participating SilverSneakers fitness center.
- Tools for tracking your physical activity.

Fitness Center memberships
- Use of exercise equipment, pool, and sauna where available. Not every fitness center has all of these options.
- Attend SilverSneakers classes designed to help improve your strength, flexibility, balance, and endurance.
- Attend events to help you work towards being healthy.
- Find online support that can help you lose weight or start an exercise program.
- Meet with a trained Program Advisor™ at the fitness center to help you get started.
- Any nonstandard fitness center services that usually have an extra fee are not included in your membership.

Humana is a Medicare Advantage PFFS plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal. Humana MyOption Optional Supplemental Benefits (OSB) are only available to members of certain Humana Medicare Advantage (MA) plans. Members of Humana plans that offer OSBs may enroll in OSBs throughout the year. Benefits may change on January 1st each year. Enrollees must use network providers for specific OSBs when stated in the Evidence of Coverage (EOC); otherwise, covered services may be received from non-network providers at a higher cost. Enrollees must continue to pay the Medicare Part B premium, their Humana premium, and the OSB premium.

Humana®

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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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