2021

# Annual Notice of Changes

**HumanaChoice**
**H5216-238 (PPO)**

Charleston
Charleston Metro Area

Humana®

# Thank you for being a Humana member

At Humana, we think the simplest way to help people feel their best is to just do what's right by them. We call it human care. And for the millions* of members who have selected Humana for their Medicare Advantage plan, that means going above and beyond what you'd expect—from helping you find a new doctor to showing you ways you may be able to spend less and feel better.

Human care also means adapting to members' needs, now and in the future. Telehealth, or virtual visits, can address a wide range of nonemergency healthcare needs. For 2021, you will have a $0 cost share—including copays, coinsurance and deductibles—for in-network telehealth visits. This includes:

- Primary care physicians
- Urgent care
- Outpatient behavioral health

This booklet is a comparison of your 2020 benefits to your 2021 benefits, and covers all the most recent plan changes. We want to ensure you have the very best Humana plan for you and understand your coverage. Remember, if you would like to keep your current plan, you don't need to do anything; it will automatically renew on January 1, 2021.

**2021 plan information will be available at Humana.com/PlanDocuments on October 15 in preparation for the Annual Election Period that runs October 15 - December 7, 2020.** To request printed documents be mailed to you, please see the back page of this booklet for instructions.

*Humana Inc. Fourth Quarter 2019 Earnings Release 2/5/2020

**HumanaChoice H5216-238 (PPO) offered by Humana Insurance Company**

# Annual Notice of Changes for 2021

You are currently enrolled as a member of HumanaChoice H5216-155 (PPO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

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**What to do now**

**1. ASK:** Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Section 2 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost-sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2021 Drug Guide and look in Section 2.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 2.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?

OMB Approval 0938-1051 (Expires: December 31, 2021)

- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2020, you will be enrolled in HumanaChoice H5216-238 (PPO).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2020**

- If you don't join another plan by **December 7, 2020**, you will be enrolled in HumanaChoice H5216-238 (PPO).
- If you join another plan by **December 7, 2020**, your new coverage will start on **January 1, 2021**. You will be automatically disenrolled from your current plan.

**Additional Resources**

- This document is available for free in Spanish.
- Please contact our Customer Care number at 1-800-457-4708 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m. seven days a week from October 1 – March 31 and 8 a.m. to 8 p.m. Monday-Friday from April 1 - September 30.
- This information is available in different formats, including braille, large print, and audio tapes. Please call Customer Care at the number listed above if you need plan information in another format.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

**About HumanaChoice H5216-238 (PPO)**

- HumanaChoice H5216-238 (PPO) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Humana Insurance Company. When it says "plan" or "our plan," it means HumanaChoice H5216-238 (PPO).

- Out-of-network/non-contracted providers are under no obligation to treat HumanaChoice H5216-238 (PPO) members, except in emergency situations. Please call our Customer Care 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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## Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for HumanaChoice H5216-238 (PPO) in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at **Humana.com/PlanDocuments**. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

| Cost | 2020 (this year) | | 2021 (next year) | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Monthly plan premium***<br><br>* Your premium may be higher or lower than this amount. See Section 2.1 for details. | **$34** | | **$0** | |
| **Maximum out-of-pocket amount**<br><br>This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.) | From network providers: **$6,700** | From network and out-of-network providers combined: **$10,000** | From network providers: **$7,550** | From network and out-of-network providers combined: **$11,300** |
| **Doctor office visits** | Primary care visits: **$5** copayment per visit<br><br>Specialist visits: **$45** copayment per visit | Primary care visits: **35%** of the total cost per visit<br><br>Specialist visits: **35%** of the total cost per visit | Primary care visits: **$5** copayment per visit<br><br>Specialist visits: **$35** copayment per visit | Primary care visits: **45%** of the total cost per visit<br><br>Specialist visits: **45%** of the total cost per visit |
| **Inpatient hospital stays**<br><br>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. | **$298** copayment per day for days 1 – 7<br><br>**$0** copayment per day for days 8 – 90 | **35%** of the total cost | **$298** copayment per day for days 1 – 7<br><br>**$0** copayment per day for days 8 – 90 | **45%** of the total cost |

| Cost | 2020 (this year) | | 2021 (next year) | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Part D prescription drug coverage**<br><br>(See Section 2.6 for details.) | Deductible: **$75**<br><br>Copayment/Coinsurance during the Initial Coverage Stage:<br><br>For a 30-day supply from a **retail pharmacy** with preferred cost-sharing<br>• Drug Tier 1: **$4**<br>• Drug Tier 2: **$12**<br>• Drug Tier 3: **$47**<br>• Drug Tier 4: **$100**<br>• Drug Tier 5: **31%** | | Deductible: **$0**<br><br>Copayment/Coinsurance during the Initial Coverage Stage:<br><br>For a 30-day supply from a **retail pharmacy** with preferred cost-sharing<br>• Drug Tier 1: **$4**<br>• Drug Tier 2: **$12**<br>• Drug Tier 3: **$47**<br>• Drug Tier 4: **$100**<br>• Drug Tier 5: **33%** | |
| | For a 30-day supply from a **retail pharmacy** with standard cost-sharing<br>• Drug Tier 1: **$10**<br>• Drug Tier 2: **$20**<br>• Drug Tier 3: **$47**<br>• Drug Tier 4: **$100**<br>• Drug Tier 5: **31%** | | For a 30-day supply from a **retail pharmacy** with standard cost-sharing<br>• Drug Tier 1: **$10**<br>• Drug Tier 2: **$20**<br>• Drug Tier 3: **$47**<br>• Drug Tier 4: **$100**<br>• Drug Tier 5: **33%** | |
| | For a 90-day supply from a **mail-order pharmacy** with preferred cost-sharing<br>• Drug Tier 1: **$0**<br>• Drug Tier 2: **$0**<br>• Drug Tier 3: **$131**<br>• Drug Tier 4: **$290**<br>• Drug Tier 5: Not available | | For a 90-day supply from a **mail-order pharmacy** with preferred cost-sharing<br>• Drug Tier 1: **$0**<br>• Drug Tier 2: **$0**<br>• Drug Tier 3: **$131**<br>• Drug Tier 4: **$290**<br>• Drug Tier 5: Not available | |

| Cost | 2020 (this year) | | 2021 (next year) | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| | For a 90-day supply from a **mail-order pharmacy** with standard cost-sharing<br>• Drug Tier 1: **$30**<br>• Drug Tier 2: **$60**<br>• Drug Tier 3: **$141**<br>• Drug Tier 4: **$300**<br>• Drug Tier 5: Not available | | For a 90-day supply from a **mail-order pharmacy** with standard cost-sharing<br>• Drug Tier 1: **$30**<br>• Drug Tier 2: **$60**<br>• Drug Tier 3: **$141**<br>• Drug Tier 4: **$300**<br>• Drug Tier 5: Not available | |

## *Annual Notice of Changes* for 2021
## Table of Contents

## SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in HumanaChoice H5216-238 (PPO) in 2021

On January 1, 2021, Humana Insurance Company will be combining HumanaChoice H5216-155 (PPO) with one of our plans, HumanaChoice H5216-238 (PPO).

**If you do nothing to change your Medicare coverage by December 7, 2020, we will automatically enroll you in our HumanaChoice H5216-238 (PPO).** This means starting January 1, 2021, you will be getting your medical and prescription drug coverage through HumanaChoice H5216-238 (PPO). If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare. If you want to change plans, you can do so between October 15 and December 7. If you are eligible for Extra Help, you may be able to change plans during other times.

The information in this document tells you about the differences between your current benefits in HumanaChoice H5216-155 (PPO) and the benefits you will have on January 1, 2021, as a member of HumanaChoice H5216-238 (PPO).

## SECTION 2 Changes to Benefits and Costs for Next Year

### Section 2.1 - Changes to the Monthly Premium

| Cost | **2020** (this year) | **2021** (next year) |
|---|---|---|
| **Monthly premium**<br>(You must also continue to pay your Medicare Part B premium.) | **$34** | **$0** |

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

### Section 2.2 - Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. These limits are called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

| Cost | 2020 (this year) | | 2021 (next year) | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **In-network maximum out-of-pocket amount**<br><br>Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.<br><br>**Combined maximum out-of-pocket amount**<br><br>Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. | **$6,700** | **$10,000** combined in-network and out-of-network | **$7,550**<br><br>Once you have paid **$7,550** out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year. | **$11,300** combined in-network and out-of-network<br><br>Once you have paid **$11,300** out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year. |

## Section 2.3 - Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at **Humana.com/PlanDocuments**. You may also call Customer Care for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2021 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

## Section 2.4 - Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated Provider Directory is located on our website at **Humana.com/PlanDocuments**. You may also call Customer Care for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2021 Provider Directory to see which pharmacies are in our network.**

## Section 2.5 - Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart* (*what is covered and what you pay*), in your *2021 Evidence of Coverage*.

Services received at Rural Health Clinics, Federally Qualified Health Clinics, and Critical Access Hospitals may be subject to the Primary Care Physician or Specialist copay or coinsurance, as applicable, for 2021.

| **Cost** | **2020** (this year) | | **2021** (next year) | |
|---|---|---|---|---|
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Abdominal aortic aneurysm screening** | | | | |
| – at a specialist's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a freestanding radiology facility | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Ambulance services** | | | | |
| • For each Medicare-covered emergency transportation by ground, you pay: | **$270** copayment per date of service | **$270** copayment per date of service | **$290** copayment per date of service | **$290** copayment per date of service |
| • For each Medicare-covered emergency transportation by air, you pay: | **$270** copayment per date of service | **$270** copayment per date of service | **$290** copayment per date of service | **$290** copayment per date of service |

| Cost | 2020 (this year) | | 2021 (next year) | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| • For each Medicare-covered non-emergency transportation by ground, you pay: | **$270** copayment per date of service | **$270** copayment per date of service | **$290** copayment per date of service | **$290** copayment per date of service |
| • For each Medicare-covered non-emergency transportation by air, you pay: | **$270** copayment per date of service | **$270** copayment per date of service | **$290** copayment per date of service | **$290** copayment per date of service |
| **Annual wellness visit** | | | | |
| – at your primary care provider's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Bone mass measurement** | | | | |
| – at a specialist's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a freestanding radiology facility | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Breast cancer screening (mammograms)** | | | | |
| – at a specialist's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a freestanding radiology facility | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Cardiac rehabilitation services** | | | | |
| – at a specialist's office | **$25** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$25** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)** | | | | |
| – at your primary care provider's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Cardiovascular disease testing** | | | | |

| Cost | **2020** (this year) | | **2021** (next year) | |
|---|---|---|---|---|
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| – at your primary care provider's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a specialist's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a freestanding laboratory facility | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Cervical and vaginal cancer screening** | | | | |
| – at your primary care provider's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a specialist's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Chiropractic services** | | | | |
| • For each Medicare-covered visit (manual manipulation of the spine to correct subluxation), you pay: | | | | |
| – at a specialist's office | **$20** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Colorectal cancer screening** | | | | |
| – at a specialist's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at an ambulatory surgical center | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **COVID-19 testing and treatment** | | | | |
| • COVID-19 testing and treatment | Cost shares may apply based on services and places of treatment | Cost shares may apply based on services and places of treatment | **$0** copayment | **$0** copayment |
| • Meals with confirmed COVID-19 diagnosis | Not Covered | Not Covered | **$0** copayment for home delivered meals -- 14 days (28 meals) | Not Covered |
| **Dental services** | | | | |

| **Cost** | **2020** (this year) | | **2021** (next year) | |
|---|---|---|---|---|
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| • For Medicare-covered dental services at a specialist's office, you pay: | **$45** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| • Supplemental dental benefits: | **DEN170**<br>**$0** copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.<br>**$0** copayment for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.<br>**$0** copayment for complete dentures, partial dentures up to 1 set(s) every 5 years.<br>**$0** copayment for panoramic film or diagnostic x-rays, recementation up to 1 every 5 years.<br>**$0** copayment for bitewing x-rays up to 1 set(s) per year.<br>**$0** copayment for adjustments to dentures, denture reline, intraoral x-rays, root canal up to 1 per year.<br>**$0** copayment for amalgam and/or composite filling, crown, emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam and/or emergency diagnostic exam, prophylaxis (cleaning) up to 2 per year. | **DEN170**<br>**$0** copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.<br>**$0** copayment for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.<br>**$0** copayment for complete dentures, partial dentures up to 1 set(s) every 5 years.<br>**$0** copayment for panoramic film or diagnostic x-rays, recementation up to 1 every 5 years.<br>**$0** copayment for bitewing x-rays up to 1 set(s) per year.<br>**$0** copayment for adjustments to dentures, denture reline, intraoral x-rays, root canal up to 1 per year.<br>**$0** copayment for amalgam and/or composite filling, crown, emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam and/or emergency diagnostic exam, prophylaxis (cleaning) up to 2 per year. | **DEN723**<br>**0%** coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.<br>**0%** coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years.<br>**0%** coinsurance for bitewing x-rays up to 1 set(s) per year.<br>**0%** coinsurance for intraoral x-rays up to 1 per year.<br>**0%** coinsurance for amalgam and/or composite filling, periodic oral exam, prophylaxis (cleaning), simple or surgical extraction up to 2 per year.<br>**0%** coinsurance for necessary anesthesia with covered service up to unlimited per year.<br>**$1000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits. | **DEN723**<br>**0%** coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.<br>**0%** coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years.<br>**0%** coinsurance for bitewing x-rays up to 1 set(s) per year.<br>**0%** coinsurance for intraoral x-rays up to 1 per year.<br>**0%** coinsurance for periodic oral exam, prophylaxis (cleaning) up to 2 per year.<br>**0%** coinsurance for necessary anesthesia with covered service up to unlimited per year.<br>**55%** coinsurance for amalgam and/or composite filling, simple or surgical extraction up to 2 per year.<br>**$1000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits.<br>Benefits received out-of-network are subject to any |

| Cost | 2020 (this year) | | 2021 (next year) | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| | **$0** copayment for periodontal maintenance up to 4 per year.<br>**$0** copayment for necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year.<br>**$1000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits. | **$0** copayment for periodontal maintenance up to 4 per year.<br>**$0** copayment for necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year.<br>**$1000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits.<br>Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. | | in-network benefit maximums, limitations, and/or exclusions. |
| **Depression screening**<br>– at your primary care provider's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Diabetes screening**<br>– at your primary care provider's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a specialist's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a freestanding laboratory facility | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Diabetes self-management training, diabetic services and supplies** | | | | |

| Cost | 2020 (this year) | | 2021 (next year) | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| • For Medicare-covered diabetes self-management training, you pay: | | | | |
| – at your primary care provider's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a specialist's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| • For each Medicare-covered diabetic supply item, you pay: | | | | |
| – at a diabetic supplier | **20%** of the total cost | **35%** of the total cost | No Change | **45%** of the total cost |
| – at an out-of-network pharmacy | Not Applicable | **35%** of the total cost | Not Applicable | **45%** of the total cost |
| • For each Medicare-covered diabetic shoes and inserts, you pay: | | | | |
| – at a durable medical equipment provider | **$10** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a prosthetics provider | **$10** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **EKG Screening** | | | | |
| – at your primary care provider's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a specialist's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Health essentials kit** | Not Covered | Not Covered | **$0** copayment -- up to 1 per year | Not Covered |
| **Hearing services** | | | | |
| • For Medicare-covered hearing services at a specialist's office, you pay: | **$45** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| • Supplemental hearing benefits: | **HER948**<br>**$0** copayment for routine hearing exams up to 1 per year. | **HER948**<br>**$0** copayment for routine hearing exams up to 1 per year. | **HER941**<br>**$0** copayment for fitting, routine hearing exams up to 1 per year. | **HER941**<br>**$0** copayment for fitting, routine hearing exams up to 1 per year. |

| Cost | 2020 (this year) | | 2021 (next year) | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| | **$0** copayment for fitting/evaluation up to 3 per year. **$199** copayment for Advanced level hearing aid up to 1 per ear per year. **$499** copayment for Premium level hearing aid up to 1 per ear per year. Note: Includes 48 batteries per aid and 3 year warranty. | **$0** copayment for fitting/evaluation up to 3 per year. **$199** copayment for Advanced level hearing aid up to 1 per ear per year. **$499** copayment for Premium level hearing aid 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. | **$0** copayment for adjustments up to 2 per year. **$699** copayment for Advanced level hearing aid up to 1 per ear per year. **$999** copayment for Premium level hearing aid up to 1 per ear per year. Note: Includes 48 batteries per aid and 3 year warranty. Fitting and adjustments are covered for 1 year after TruHearing hearing aid purchase. | **$0** copayment for adjustments up to 2 per year. **$699** copayment for Advanced level hearing aid up to 1 per ear per year. **$999** copayment for Premium level hearing aid up to 1 per ear per year. Note: Includes 48 batteries per aid and 3 year warranty. Fitting and adjustments are covered for 1 year after TruHearing hearing aid purchase. 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. |
| **HIV screening** | | | | |
| – at your primary care provider's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a specialist's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a freestanding laboratory facility | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Home health agency care** | | | | |
| • For Medicare-covered home health visits, you pay: | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |

| Cost | 2020 (this year) | | 2021 (next year) | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Humana Well Dine® meal program** | **$0** copayment for Humana Well Dine ® meal program. Receive 2 meals per day for 5 days, up to 10 meals delivered to member's home after an inpatient stay in a hospital or nursing facility. Limited to 4 times per year. | Not Covered | **$0** copayment for Humana Well Dine ® meal program. Receive 2 meals per day for 7 days, up to 14 meals delivered to member's home after an inpatient stay in a hospital or nursing facility. Limited to 4 times per year. | Not Covered |
| **Inpatient hospital care**<br>• For a Medicare-covered stay at a hospital, you pay: | **$298** copayment per day for days 1 - 7<br>**$0** copayment per day for days 8 - 90 | **35%** of the total cost | No Change | **45%** of the total cost |
| **Inpatient mental health care**<br>• For a Medicare-covered stay at a hospital, you pay: | **$298** copayment per day for days 1 - 7<br>**$0** copayment per day for days 8 - 90 | **35%** of the total cost | No Change | **45%** of the total cost |
| • For a Medicare-covered stay at an inpatient psychiatric facility, you pay: | **$587** copayment per day for days 1 - 3<br>**$0** copayment per day for days 4 - 90 | **50%** of the total cost | **$298** copayment per day for days 1 - 6<br>**$0** copayment per day for days 7 - 90 | No Change |
| **Medical nutrition therapy**<br>– at your primary care provider's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a specialist's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Medicare Part B prescription drugs** | | | | |

| **Cost** | **2020** (this year) | | **2021** (next year) | |
|---|---|---|---|---|
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| • For Medicare-covered Part B drugs, you pay: | | | | |
| – at a pharmacy | **20%** of the total cost | **35%** of the total cost | No Change | **45%** of the total cost |
| – at your primary care provider's office | **20%** of the total cost | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a specialist's office | **20%** of the total cost | **35%** of the total cost | No Change | **45%** of the total cost |
| • For chemotherapy drugs, you pay: | | | | |
| – at a hospital facility as an outpatient | **20%** of the total cost | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a specialist's office | **20%** of the total cost | **35%** of the total cost | No Change | **45%** of the total cost |
| **Obesity screening and therapy to promote sustained weight loss** | | | | |
| – at your primary care provider's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Opioid treatment program services** | | | | |
| • For each Medicare-covered opioid treatment services visit, you pay: | | | | |
| – at a specialist's office | **$40** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| – at a hospital facility for partial hospitalization | **$55** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$120** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| **Outpatient diagnostic tests and therapeutic services and supplies** | | | | |

| **Cost** | **2020** (this year) | | **2021** (next year) | |
|---|---|---|---|---|
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| • For diagnostic procedures and tests, you pay: | | | | |
| – at your primary care provider's office | **$5** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a specialist's office | **$45** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$100** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at an urgent care center | **$45** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| • For advanced imaging services (MRI, MRA, PET, or CT Scan), you pay: | | | | |
| – at your primary care provider's office | **$180** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a specialist's office | **$180** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a freestanding radiology facility | **$180** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$275** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| • For basic radiological services, you pay: | | | | |
| – at your primary care provider's office | **$5** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a specialist's office | **$45** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$100** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| – at a freestanding radiology facility | **$50** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| – at an urgent care center | **$45** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| • For diagnostic mammography, you pay: | | | | |
| – at a specialist's office | **$45** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| – at a freestanding radiology facility | **$50** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$70** copayment | **35%** of the total cost | No Change | **45%** of the total cost |

| Cost | **2020** (this year) | | **2021** (next year) | |
|---|---|---|---|---|
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| • For radiation therapy, you pay: | | | | |
| – at a specialist's office | **$45** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| – at a freestanding radiology facility | **20%** of the total cost | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **20%** of the total cost | **35%** of the total cost | No Change | **45%** of the total cost |
| • For nuclear medicine services, you pay: | | | | |
| – at a freestanding radiology facility | **$460** copayment | **35%** of the total cost | **$270** copayment | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$510** copayment | **35%** of the total cost | **$495** copayment | **45%** of the total cost |
| • For Coumadin® clinic services, you pay: | | | | |
| – at a hospital facility as an outpatient | **$10** copayment | **35%** of the total cost | **$0** copayment | **45%** of the total cost |
| • For sleep study services, you pay: | | | | |
| – at a member's home | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a specialist's office | **$45** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$100** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| • For wound care, you pay: | | | | |
| – at a hospital facility as an outpatient | **$45** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| • For diagnostic colonoscopy, you pay: | | | | |
| – at a specialist's office | **$45** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| – at an ambulatory surgical center | **$295** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$345** copayment | **35%** of the total cost | No Change | **45%** of the total cost |

| Cost | **2020** (this year) | | **2021** (next year) | |
|---|---|---|---|---|
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| • For lab services, you pay: | | | | |
| – at your primary care provider's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a specialist's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a freestanding laboratory facility | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$45** copayment | **35%** of the total cost | **$0** copayment | **45%** of the total cost |
| – at an urgent care center | **$45** copayment | **35%** of the total cost | **$0** copayment | **45%** of the total cost |
| **Outpatient hospital observation** | | | | |
| • For each Medicare-covered observation services visit, you pay: | | | | |
| – at a hospital facility as an outpatient | **$298** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Outpatient mental health care** | | | | |
| • For each Medicare-covered individual/group therapy visit, you pay: | | | | |
| – at a specialist's office | **$40** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| – for a virtual visit | **$40** copayment | Not Applicable | **$0** copayment | Not Applicable |
| – at a hospital facility for partial hospitalization | **$55** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$120** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| **Outpatient rehabilitation services** | | | | |

| Cost | **2020** (this year) | | **2021** (next year) | |
|---|---|---|---|---|
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| • For Medicare-covered physical therapy, you pay: | | | | |
| – at a specialist's office | **$25** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a Comprehensive Outpatient Rehabilitation Facility (CORF) | **$25** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$40** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| • For Medicare-covered occupational therapy or speech/language therapy, you pay: | | | | |
| – at a specialist's office | **$25** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a Comprehensive Outpatient Rehabilitation Facility (CORF) | **$25** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$40** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Outpatient substance abuse services** | | | | |
| • For each Medicare-covered individual/group therapy visit, you pay: | | | | |
| – at a specialist's office | **$40** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| – for a virtual visit | **$40** copayment | Not Applicable | **$0** copayment | Not Applicable |
| – at a hospital facility for partial hospitalization | **$55** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$120** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| **Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers** | | | | |

| Cost | **2020** (this year) | | **2021** (next year) | |
|---|---|---|---|---|
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| • For each Medicare-covered surgical services visit, you pay: | | | | |
| – at a primary care provider's office | **$5** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a specialist's office | **$45** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| – at an ambulatory surgical facility | **$295** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$345** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Over-the-counter (OTC) mail order** | **$50** maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products. | Not Covered | **$25** maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products. | Not Covered |
| **Physical exam (routine)** | | | | |
| – at your primary care provider's office | **$0** copayment, limit 1 visit(s) per year | **35%** of the total cost, limit 1 visit(s) per year | No Change | **45%** of the total cost, limit 1 visit(s) per year |
| **Podiatry services** | | | | |
| • For each Medicare-covered visit (medically necessary foot care), you pay: | | | | |
| – at a specialist's office | **$45** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| • For each routine visit, you pay: | | | | |
| – at a specialist's office | Not Applicable | Not Applicable | **$35** copayment, limit 6 combined in-network and out-of-network visit(s) per year | **$35** copayment, limit 6 combined in-network and out-of-network visit(s) per year |
| **Prostate cancer screening exams** | | | | |
| – at your primary care provider's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |

| Cost | **2020** (this year) | | **2021** (next year) | |
|---|---|---|---|---|
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| – at a specialist's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Physician/Practitioner services, including doctor's office visits** | | | | |
| • For each office visit for Medicare-covered services, you pay: | | | | |
| – at your primary care provider's office | **$5** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – for a primary care physician-virtual visit | **$5** copayment | Not Applicable | **$0** copayment | Not Applicable |
| – at a specialist's office | **$45** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| – for a specialist's office-virtual visit | Not Applicable | Not Applicable | **$35** copayment | Not Applicable |
| **Pulmonary rehabilitation services** | | | | |
| – at a specialist's office | **$25** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$25** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Screening and counseling to reduce alcohol misuse** | | | | |
| – at your primary care provider's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Screening for lung cancer with low dose computed tomography (LDCT)** | | | | |
| – at a specialist's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a freestanding radiology facility | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a hospital facility as an outpatient | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **Screening for sexually transmitted infections (STIs) and counseling to prevent STIs** | | | | |
| – at your primary care provider's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |

| Cost | **2020** (this year) | | **2021** (next year) | |
|---|---|---|---|---|
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Services to treat kidney disease**<br>• For kidney disease education services, you pay:<br>– at your primary care provider's office<br>– at a specialist's office | **$0** copayment<br>**$0** copayment | **35%** of the total cost<br>**35%** of the total cost | No Change<br>No Change | **45%** of the total cost<br>**45%** of the total cost |
| **Skilled nursing facility (SNF) care**<br>• For a Medicare-covered stay at a skilled nursing facility, you pay: | **$0** copayment per day for days 1 - 20<br>**$178** copayment per day for days 21 - 100 | **35%** of the total cost for days 1 - 100 | **$0** copayment per day for days 1 - 20<br>**$184** copayment per day for days 21 - 100 | **45%** of the total cost for days 1 - 100 |
| **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)**<br>– at your primary care provider's office<br>– at a specialist's office | **$0** copayment<br>**$0** copayment | **35%** of the total cost<br>**35%** of the total cost | No Change<br>No Change | **45%** of the total cost<br>**45%** of the total cost |
| **Special Supplemental Benefits for the Chronically Ill**<br>• Member Support | Not Covered | Not Covered | **$500** maximum benefit coverage amount per year for items/services tailored to the member's specific need based on Case Manager and/or PCP authorization. | Not Covered |
| **Supervised Exercise Therapy (SET)**<br>– at a specialist's office<br>– at a hospital facility as an outpatient | **$25** copayment<br>**$25** copayment | **35%** of the total cost<br>**35%** of the total cost | No Change<br>No Change | **45%** of the total cost<br>**45%** of the total cost |
| **Transportation** | **$0** copayment for | Not Covered | **$0** copayment for | Covered |

| Cost | **2020** (this year) | | **2021** (next year) | |
|---|---|---|---|---|
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| | plan approved location up to 12 one-way trip(s) per year.<br>This benefit is not to exceed 50 miles per trip. | | plan approved location up to 24 one-way trip(s) per year.<br>This benefit is not to exceed 50 miles per trip. | |
| **Urgently needed services** | | | | |
| • For Medicare-covered urgently needed services, you pay: | | | | |
| – at your primary care provider's office | **$5** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| – at a specialist's office | **$45** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| – at an urgent care center | **$45** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| – for an urgent care-virtual visit | **$45** copayment | Not Applicable | **$0** copayment | Not Applicable |
| **Vision care** | | | | |
| • For Medicare-covered vision services at a specialist's office, you pay: | **$45** copayment | **35%** of the total cost | **$35** copayment | **45%** of the total cost |
| • For glaucoma screening, you pay: | | | | |
| – at a specialist's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| • For diabetic eye exam at all places of treatment, you pay: | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |
| **"Welcome to Medicare" preventive visit** | | | | |
| – at your primary care provider's office | **$0** copayment | **35%** of the total cost | No Change | **45%** of the total cost |

## Section 2.6 - Changes to Part D Prescription Drug Coverage

### Changes to Our Drug Guide

Our list of covered drugs is called a Formulary or "Drug Guide." A copy of our Drug Guide is provided electronically. The Drug Guide provided electronically includes many - *but not all* - of the drugs that we will cover next year. If you

don't see your drug on this list, it might still be covered. **You can get the *complete* Drug Guide** by calling Customer Care (see the back cover) or visiting our website **(Humana.com/PlanDocuments)**.

We made changes to our Drug Guide, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug Guide to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
  - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint* (*coverage decisions, appeals, complaints*)) or call Customer Care.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Care to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Meanwhile, you and your doctor will need to decide what to do before your temporary supply of the drug runs out.

- **Perhaps you can find a different drug** covered by the plan that might work just as well for you. You can call Customer Care to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.
- **You and your doctor can ask the plan to make an exception for you** and cover the drug. To learn what you must do to ask for an exception, see the Evidence of Coverage provided electronically. Look for Chapter 9 of the *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.
- **If we approve your request for an exception**, our approval usually is valid until the end of the plan year. A new formulary exception will need to be submitted for the upcoming plan year. To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

Most of the changes in the Drug Guide are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug Guide during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug Guide as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug Guide, see Chapter 5, Section 6 of the Evidence of Coverage.)

## Changes to Prescription Drug Costs

*Note*: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you**. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the

"LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and haven't received this insert by September 30, please call Customer Care and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, which is located on our website at **Humana.com/PlanDocuments**. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.)

**Changes to the Deductible Stage**

| **Stage** | **2020** (this year) | **2021** (next year) |
|---|---|---|
| **Stage 1: Yearly Deductible Stage** | The deductible is **$75**.<br><br>During this stage, you pay **$4** cost-sharing for drugs on Tier 1, **$12** cost-sharing for drugs on Tier 2 and the full cost of drugs on Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible. | Because we have no deductible, this payment stage does not apply to you. |

**Changes to Your Cost Sharing in the Initial Coverage Stage**

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

| **Stage** | **2020** (this year) | **2021** (next year) |
|---|---|---|
| **Stage 2: Initial Coverage Stage**<br><br>During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost**.<br><br>The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*.<br><br>We changed the tier for some of the drugs on our Drug Guide. To see if your drugs will be in a different tier, look them up on the Drug Guide. | Your cost for a one-month supply at a network pharmacy:<br><br>**Preferred Generic:**<br>*Standard cost sharing:* You pay **$10** per prescription.<br><br>*Preferred cost sharing:* You pay **$4** per prescription.<br><br>**Generic:**<br>*Standard cost sharing:* You pay **$20** per prescription.<br><br>*Preferred cost sharing:* You pay **$12** per prescription. | Your cost for a one-month supply at a network pharmacy:<br><br>**Preferred Generic:**<br>*Standard cost sharing:* You pay **$10** per prescription.<br><br>*Preferred cost sharing:* You pay **$4** per prescription.<br><br>**Generic:**<br>*Standard cost sharing:* You pay **$20** per prescription.<br><br>*Preferred cost sharing*: You pay **$12** per prescription. |

| Stage | **2020** (this year) | **2021** (next year) |
|---|---|---|
| | **Preferred Brand:**<br>*Standard cost sharing:* You pay **$47** per prescription.<br><br>*Preferred cost sharing*: You pay **$47** per prescription.<br><br>**Non-Preferred Drug:**<br>*Standard cost sharing:* You pay **$100** per prescription.<br><br>*Preferred cost sharing*: You pay **$100** per prescription.<br><br>**Specialty Tier:**<br>*Standard cost sharing:* You pay **31%** per prescription.<br><br>*Preferred cost sharing:* You pay **31%** per prescription.<br><br>Once your total drug costs have reached **$4,020**, you will move to the next stage (the Coverage Gap Stage). | **Preferred Brand:**<br>*Standard cost sharing:* You pay **$47** per prescription.<br><br>*Preferred cost sharing*: You pay **$47** per prescription.<br><br>**Non-Preferred Drug:**<br>*Standard cost sharing:* You pay **$100** per prescription.<br><br>*Preferred cost sharing*: You pay **$100** per prescription.<br><br>**Specialty Tier:**<br>*Standard cost sharing:* You pay **33%** per prescription.<br><br>*Preferred cost sharing*: You pay **33%** per prescription.<br><br>Once your total drug costs have reached **$4,130**, you will move to the next stage (the Coverage Gap Stage). |

**Changes to the Coverage Gap and Catastrophic Coverage Stages**

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

## SECTION 3 Deciding Which Plan to Choose

### Section 3.1 - If you want to stay in HumanaChoice H5216-238 (PPO)

**To stay in our plan you don't need to do anything.** If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our plan for HumanaChoice H5216-238 (PPO).

### Section 3.2 - If you want to change plans

We hope to keep you as a member next year but if you want to change for 2021 follow these steps:

**Step 1: Learn about and compare your choices**

- You can join a different Medicare health plan timely,

- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2021*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

**Step 2: Change your coverage**

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from HumanaChoice H5216-238 (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from HumanaChoice H5216-238 (PPO).
- To **change to Original Medicare without a prescription drug plan,** you must either:
  - Send us a written request to disenroll. Contact Customer Care if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
  - – *Or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

## SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2021.

**Are there other times of the year to make a change?**

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2021, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2021. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

## SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

A State Health Insurance Assistance Program (SHIP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. State Health Insurance Assistance Program (SHIP) counselors can

help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call your State Health Insurance Assistance Program at the number listed in "Exhibit A" in the back of this booklet.

## SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria; including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the ADAP program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP program (the name and phone numbers for this organization are in "Exhibit A" in the back of this booklet).

## SECTION 7 Questions?

### Section 7.1 - Getting Help from HumanaChoice H5216-238 (PPO)

Questions? We're here to help. Please call Customer Care at 1-800-457-4708. (TTY only, call 711.) We are available for phone calls from 8 a.m. to 8 p.m. seven days a week from Oct. 1 – Mar. 31 and 8 a.m. to 8 p.m. Monday-Friday from Apr. 1 - Sept. 30. Calls to these numbers are free.

**Read your 2021 *Evidence of Coverage* (it has details about next year's benefits and costs)**

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2021. For details, look in the 2021 *Evidence of Coverage* for HumanaChoice H5216-238 (PPO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at **Humana.com/PlanDocuments**. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

**Visit our Website**

You can also visit our website at **Humana.com/PlanDocuments**. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug Guide).

## Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

**Call 1-800-MEDICARE (1-800-633-4227)**

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

**Visit the Medicare Website**

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare.)

**Read *Medicare & You 2021***

You can read *Medicare & You 2021* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

# Exhibit A- State Agency Contact Information

This section provides the contact information for the state agencies referenced in this Annual Notice of Changes. If you have trouble locating the information you seek, please contact Customer Care at the phone number on the back cover of this booklet.

| South Carolina | |
|---|---|
| **SHIP Name and Contact Information** | (I-CARE) Insurance Counseling Assistance and Referrals for Elders<br>1301 Gervais Street<br>Suite 350<br>Columbia,SC 29201<br>1-800-868-9095 (toll free)<br>1-803-734-9900 (local)<br>1-803-734-9886 (fax)<br>http://aging.sc.gov/Pages/default.aspx |
| **Quality Improvement Organization** | KEPRO<br>5201 W. Kennedy Blvd.<br>Suite 900<br>Tampa,FL 33609<br>1-888-317-0751<br>1-855-843-4776 (TTY)<br>1-833-868-4058 (Fax) |
| **State Medicaid Office** | South Carolina Healthy Connections Medicaid<br>P.O. Box 8206<br>Columbia,SC 29202-8206<br>1-888-549-0820 (toll free)<br>1-803-898-2500 (local)<br>1-888-842-3620 (TTY)<br>http://www.scdhhs.gov |
| **AIDS Drug Assistance Program** | South Carolina AIDS Drug Assistance Program (ADAP)<br>SC Drug Assistance Program/Direct Dispensing Program<br>3rd Floor, Mills Jarrett Box 101106<br>Columbia,SC 29211<br>1-800-856-9954 (toll free)<br>http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/AIDSDrugAssistancePlan |

# Notice of Privacy Practices for your personal health information

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**The privacy of your personal and health information is important. You don't need to do anything unless you have a request or complaint.**

We may change our privacy practices and the terms of this notice at any time, as allowed by law. Including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

**What is personal and health information?**
Personal and health information includes both medical information and personal information, like your name, address, telephone number, or Social Security number. The term "information" in this notice includes any personal and health information. This includes information created or received by a healthcare provider or health plan. The information relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare.

**How do we protect your information?**
We have a responsibility to protect the privacy of your information in all formats including electronic, written and oral information. We have safeguards in place to protect your information in various ways including:
- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our employees about our privacy program and procedures

**How do we use and disclose your information?**
We use and disclose your information:
- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services

We have the right to use and disclose your information:
- To a doctor, a hospital, or other healthcare provider so you can receive medical care.
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments.
- For healthcare operation activities. Including processing your enrollment, responding to your inquiries, coordinating your care, improving quality, and determining premiums.
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform, plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations. For example, to allow your plan sponsor to obtain bids from other health plans. Your detailed health information will not be shared with your plan sponsor. We will ask your permission or your plan sponsor has to certify they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or treatment alternatives that may be of interest to you. If you have opted out as described below, we will not contact you.
- To your family and friends if you are unavailable to communicate, such as in an emergency
- To your family and friends or any other person you identify. This applies if the information is directly relevant to their involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm if the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation

- To public health agencies, if we believe that there is a serious health or safety threat
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence
- In response to a court or administrative order, subpoena, discovery request, or other lawful process
- For law enforcement purposes, to military authorities, and as otherwise required by law
- To help with disaster relief efforts
- For compliance programs and health oversight activities
- To fulfill our obligations under any workers' compensation law or contract
- To avert a serious and imminent threat to your health or safety or the health or safety of others
- For research purposes in limited circumstances
- For procurement, banking, or transplantation of organs, eyes, or tissue
- To a coroner, medical examiner, or funeral director.

**Will we use your information for purposes not described in this notice?**
We will not use or disclose your information for any reason that is not described in this notice, without your written permission. You may cancel your permission at any time by notifying us in writing. The following uses and disclosures will require your written permission:
- Most uses and disclosures of psychotherapy notes
- Marketing purposes
- Sale of personal and health information

**What do we do with your information when you are no longer a member?**
Your information may continue to be used for purposes described in this notice. This includes when you do not obtain coverage through us. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

**What are my rights concerning my information?**
We are committed to responding to your rights request in a timely manner
- Access - You have the right to review and obtain a copy of your information that may be used to make decisions about you. You also may receive a summary of this health information. If you request copies, we may charge you a fee for the labor for copying, supplies for creating the copy (paper or electronic) and postage.
- Adverse Underwriting Decision - If we decline your application for insurance, you have the right to be provided a reason for the denial.
- Alternate Communications - To avoid a life- threatening situation, you have the right to receive your information in a different manner or at a different place. We will accommodate your request if it is reasonable.
- Amendment - You have the right to request an amendment of information we maintain about you if you believe that the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.
- Disclosure - You have the right to receive a listing of instances in which we or our business associates have disclosed your information. This does not apply to treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee.
- Notice - You have the right to request and receive a written copy of this notice any time.
- Restriction - You have the right to ask to limit how your information is used or disclosed. We are not required to agree to the limit, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted limitation.

**What types of communications can I opt out of that are made to me?**
- Appointment reminders
- Treatment alternatives or other health-related benefits or services
- Fundraising activities

**How do I exercise my rights or obtain a copy of this notice?**
All of your privacy rights can be exercised by obtaining the applicable forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762
- Accessing our Website at **Humana.com** and going to the Privacy Practices link
- Send completed request form to:
  Humana Inc.
  Privacy Office 003/10911
  101 E. Main Street
  Louisville, KY 40202

* This right applies only to our Massachusetts residents in accordance with state regulations.

**If I believe that my privacy has been violated, what should I do?**
If you believe that your privacy has been violated you may file a complaint with us by calling us at 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You can also e-mail your complaint to OCRComplaint@hhs.gov. If you elect to file a complaint, your benefits will not be affected and we will not punish or retaliate against you in any way.

We support your right to protect the privacy of your personal and health information.

We follow all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, we follow the law, rule, or regulation which provides greater protection.

We are required by law to abide by the terms of this notice currently in effect.

**What will happen if my information is used or disclosed inappropriately?**
We are required by law to provide individuals with notice of our legal duties and privacy practices regarding personal and health information. If a breach of unsecured personal and health information occurs, we will notify you in a timely manner.

The following affiliates and subsidiaries also adhere to our privacy program and procedures:

Arcadian Health Plan, Inc.
CarePlus Health Plans, Inc.
Cariten Health Plan, Inc.
Cariten Insurance Company CHA HMO, Inc.
CompBenefits Company
CompBenefits Dental, Inc.
CompBenefits Insurance Company
CompBenefits of Alabama, Inc.
CompBenefits of Georgia, Inc.
DentiCare, Inc.
Emphesys Insurance Company
HumanaDental Insurance Company
Humana Benefit Plan of Illinois, Inc. fna OSF Health Plans, Inc.
Humana Benefit Plan of Texas, Inc.
Humana Employers Health Plan of Georgia, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Humana Health Company of New York, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of California, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.

Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Humana Insurance Company of New York
Humana Insurance of Puerto Rico, Inc.
Humana Medical Plan, Inc.
Humana Medical Plan of Michigan, Inc.
Humana Medical Plan of Pennsylvania, Inc.
Humana Medical Plan of Utah, Inc.
Humana Regional Health Plan, Inc.
Humana Wisconsin Health Organization Insurance Corporation
Managed Care Indemnity, Inc.
The Dental Concern, Inc.

Effective 9/2013

# Important!

## At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  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 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**.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

## Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides 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.

## Language assistance services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

**Español (Spanish):** Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
**繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。
**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
**Русский (Russian):** Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
**Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
**Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.
**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
**日本語 (Japanese):** 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
**فارسی (Farsi)**
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
**Diné Bizaad (Navajo):** Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę nika'adoowoł.
**العربية (Arabic)**
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

# The information you need is just a click away

Starting October 15, 2020, you can view and search these 2021 plan documents online at **Humana.com/PlanDocuments**:

- **Evidence of Coverage:** Details about your plan, including benefits and costs
- **Drug List:** List of drugs covered in your plan
- **Provider Directory:** List of providers in your plan's network

**Humana.com/PlanDocuments** has the most up-to-date information about your plan and is easy to search so you can find the information you are looking for quickly.

We're here to help. If you have trouble using these online tools, please call the number on the back of your Humana member ID card for support.

To get paper copies of these documents by mail, submit your request 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 List," and/or "Provider Directory." Please allow up to two weeks to receive the documents by mail.

**Humana Inc.**
PO Box 14168
Lexington, KY 40512-4168

H5216155000238002ANOC21

Important information about changes to your Medicare Advantage and prescription drug plan

## Look inside

Here's a summary of your **HumanaChoice H5216-238 (PPO)** that takes effect on January 1, 2021.

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