2022

Summary of Benefits

HumanaChoice H5216-043 (PPO)

Texas
Select Counties in Texas

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, 2023.
- ☐ 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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HumanaChoice H5216-043 (PPO)

Texas
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Our service area includes the following county/counties in Texas: Aransas, Armstrong, Atascosa, Austin, Bandera, Bee, Bexar, Bowie, Brazoria, Caldwell, Calhoun, Callahan, Cameron, Carson, Cass, Chambers, Coleman, Collin, Colorado, Comal, Comanche, Cooke, Dallas, Deaf Smith, Delta, Denton, Dimmit, Eastland, Ector, Edwards, El Paso, Ellis, Erath, Fannin, Fayette, Fort Bend, Frio, Galveston, Grayson, Grimes, Guadalupe, Hardin, Harris, Hidalgo, Hill, Hood, Howard, Jefferson, Jim Wells, Johnson, Jones, Kaufman, Kendall, Kerr, Kleberg, Lamar, Liberty, Lubbock, Martin, Matagorda, Maverick, McLennan, Medina, Midland, Montague, Montgomery, Navarro, Nueces, Orange, Palo Pinto, Parker, Polk, Potter, Randall, Real, Red River, Rockwall, San Jacinto, San Patricio, Shackelford, Tarrant, Taylor, Titus, Trinity, Tyler, Victoria, Walker, Waller, Washington, Wharton, Willacy, Wilson, Wise, Wood, Zavala.

Let's talk about HumanaChoice H5216-043 (PPO)

Find out more about the HumanaChoice H5216-043 (PPO) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice H5216-043 (PPO) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, ask us for the "Evidence of Coverage".

To be eligible

To join HumanaChoice H5216-043 (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

HumanaChoice H5216-043 (PPO)

How to reach us:

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

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

October 1 - March 31:

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

April 1 - September 30:

Call Monday - Friday, 8 a.m. - 8 p.m.

Or visit our website:
Humana.com/medicare

More about HumanaChoice H5216-043 (PPO)

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). HumanaChoice H5216-043 (PPO) 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

PLAN COSTS	
Monthly plan premium You must keep paying your Medicare Part B premium.	**$10** If you receive premium assistance, your plan premium may be reduced.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	**$250** for 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** in-network **$11,300** 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.	**$475** copay per day for days 1-25 **$0** copay per day for days 26-90
OUTPATIENT HOSPITAL COVERAGE		
Outpatient surgery at outpatient hospital	**$325** copay	**40%** of the cost
Outpatient surgery at ambulatory surgical center	**$255** copay	**40%** of the cost
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**$25** copay
Specialists	**$35** copay	**$65** copay

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

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE		
	Our plan covers many preventive services at no cost when you see an in-network provider including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • 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	**$0** copay or **40%** of the cost, depending on the service and where service is provided Any additional preventive services approved by Medicare during the contract year will be covered.

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

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
	Any additional preventive services approved by Medicare during the contract year will be covered.	
EMERGENCY CARE		
Emergency room If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	**$90** copay	**$90** copay
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$35** copay at an urgent care center	**40%** of the cost 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	**$35** to **$75** copay	**$65** copay or **40%** of the cost
Diagnostic radiology	**$180** to **$325** copay	**40%** of the cost
Lab services	**$0** to **$50** copay	**40%** of the cost
Diagnostic tests and procedures	**$0** to **$175** copay	**$25** to **$65** copay or **40%** of the cost
Outpatient X-rays	**$0** to **$95** copay	**$25** to **$65** copay or **40%** of the cost
Radiation therapy	**$45** copay or **20%** of the cost	**$65** copay or **40%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**$35** copay	**$65** copay

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

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Routine hearing	**HER941** • **$0** copayment for routine hearing exams up to 1 per year. • **$699** copayment for each Advanced level hearing aid up to 1 per ear per year. • **$999** copayment for each Premium level hearing aid up to 1 per ear per year. Hearing aid purchase includes: • Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models	**HER941** • **$0** copayment for routine hearing exams up to 1 per year. • **$699** copayment for each Advanced level hearing aid up to 1 per ear per year. • **$999** copayment for each Premium level hearing aid up to 1 per ear per year. **You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (for TTY, dial 711).**
DENTAL SERVICES The cost-share indicated below is what you pay for the covered service.		
Medicare-covered dental	**$35** copay	**$65** copay
Routine dental Dental benefits may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**. 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.	**DEN978** • **0%** coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **0%** coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years. • **0%** coinsurance for bitewing x-rays up to 1 set(s) per year. • **0%** coinsurance for intraoral x-rays up to 1 per year. • **0%** coinsurance for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **0%** coinsurance for necessary anesthesia with covered service up to unlimited per year. • **50%** coinsurance for amalgam and/or composite filling, simple or surgical extraction up to 2 per year.	**DEN978** • **50%** coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **50%** coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years. • **50%** coinsurance for bitewing x-rays up to 1 set(s) per year. • **50%** coinsurance for intraoral x-rays up to 1 per year. • **50%** coinsurance for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **50%** coinsurance for necessary anesthesia with covered service up to unlimited per year. • **55%** coinsurance for amalgam and/or composite filling, simple or surgical extraction up to 2 per year.

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

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
	• **70%** coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **70%** coinsurance for periodontal maintenance up to 4 per year. • **$2000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits.	• **75%** coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **75%** coinsurance for periodontal maintenance up to 4 per year. • **$2000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
VISION SERVICES		
Medicare-covered vision services	**$35** copay	**$65** copay
Medicare-covered diabetic eye exam	**$0** copay	**40%** of the cost
Medicare-covered glaucoma screening	**$0** copay	**40%** of the cost
Medicare-covered eyewear (post-cataract)	**$0** copay	**$0** copay

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

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Routine vision Refraction is only covered when billed as part of the routine vision exam. The provider locator for routine vision can be found at **Humana.com** > Find a Doctor > select Vision care icon > Vision coverage through Medicare Advantage plans.	**VIS751** • **$0** copayment for routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for routine exam. • **$100** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year.	**VIS751** • **$0** copayment for routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for routine exam. • **$100** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$318** copay per day for days 1-5 **$0** copay per day for days 6-90	**$475** copay per day for days 1-25 **$0** copay per day for days 26-90
Outpatient group and individual therapy visits Cost share may vary depending on where service is provided.	**$30** to **$100** copay	**$65** copay or **40%** of the cost
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	**40%** of the cost for days 1-100

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

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
PHYSICAL THERAPY		
Cost share may vary depending on the service and where service is provided.	**$25** copay	**$65** copay or **40%** of the cost
AMBULANCE		
Ambulance (ground)	**$290** copay per date of service	**$290** copay per date of service
Ambulance (air)	**20%** of the cost	**20%** of the cost
TRANSPORTATION		
	Not covered	Not covered

Prescription Drug Benefits

MEDICARE PART B DRUGS		
Chemotherapy drugs	**20%** of the cost	**40%** of the cost
Other Part B drugs	**20%** of the cost	**20%** of the cost
PRESCRIPTION DRUGS		

If you don't receive Extra Help for your drugs, you'll pay the following:

Deductible This plan has a **$250** deductible for Tier 4, Tier 5 drugs. You pay the full cost of these drugs until you reach $250. Then, you only pay your cost-share. There is no deductible for Select Insulins as part of the Insulin Savings Program. During this stage, you will pay no more than $35 for a one-month (up to a 30-day) supply for Select Insulins. See the Additional Drug Coverage section of this document for additional details.

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach **$4,430**. 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. As part of the Insulin Savings Program, you will pay no more than $35 for a one-month (up to a 30-day) supply for Select Insulins in the initial coverage stage. See the Additional Drug Coverage section of this document for specific details.

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

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	$3	$9	$3	$0
Tier 2: Generic	$10	$30	$10	$0
Tier 3: Preferred Brand	$47	$141	$47	$131
Tier 4: Non-Preferred Drug	$99	$297	$99	$287
Tier 5: Specialty Tier	28%	N/A	28%	N/A

Standard cost-sharing				
Pharmacy options	**Retail** All other network retail pharmacies.		**Mail order** Walmart Mail, PillPack	
	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	28%	N/A	28%	N/A

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

Other pharmacies are available in our network.

Specialty drugs are limited to a 30-day supply.

If you receive Extra Help for your drugs, you'll pay the following:

Deductible You may pay **$0** or **$99** depending on your level of Extra Help (for Tier 4, Tier 5). If your deductible is **$99**, you pay the full cost of these drugs until you reach **$99**. Then, you only pay your cost-share.

Pharmacy cost-sharing		
For generic drugs (including brand drugs treated as generic), either:	**30-day supply** **$0** copay; or **$1.35** copay; or **$3.95** copay ; or **15%** of the cost	**90-day supply** **$0** copay; or **$1.35** copay; or **$3.95** copay ; or **15%** of the cost
For all other drugs, either:	**$0** copay; or **$4** copay; or **$9.85** copay ; or **15%** of the cost	**$0** copay; or **$4** copay; or **$9.85** copay ; or **15%** of the cost
ADDITIONAL DRUG COVERAGE		
Erectile dysfunction (ED) drugs	Covered at Tier 1 cost-share amount.	

This plan participates in the Insulin Savings Program which provides affordable, predictable copayments on Select Insulins through the first three drug payment stages (Deductible (if applicable), Initial Coverage and Coverage Gap) of the Part D benefit. The Insulin Savings Program does not apply to the Catastrophic Coverage stage. To find out which drugs are Select Insulins, please check this plan's Humana Drug Guide. You can identify Select Insulins by the "**ISP**" indicator in the Drug Guide. You are not eligible for this program if you receive Extra Help.

Your share of the cost for Select Insulins through the Deductible Stage (if applicable), Initial Coverage Stage and Coverage Gap Stage as part of the Insulin Savings Program:

Preferred cost-sharing for Select Insulins				
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 3: Preferred Brand	**$35**	**$105**	**$35**	**$95**
Standard cost-sharing for Select Insulins				
Pharmacy options	**Retail** All other network retail pharmacies.		**Mail Order** Walmart Mail, PillPack	
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 3: Preferred Brand	**$35**	**$105**	**$35**	**$105**

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 your "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 **25 percent** of the plan's cost for covered generic drugs until your costs total **$7,050** — which is the end of the coverage gap. As part of the Insulin Savings Program, you will pay no more than $35 for a one-month (up to a 30-day) supply for Select Insulins in the coverage gap. See the Additional Drug Coverage section of this document for specific details. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the following:

Tier 1 (Preferred Generic) - All Drugs

Tier 2 (Generic) - All Drugs

Tier 3 (Preferred Brand) - Select Insulin Drugs

For more information on cost sharing in the coverage gap, please call us or access your Evidence of Coverage online.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,050**, you pay the greater of:

- **5%** of the cost, or
- **$3.95** copay for generic (including brand drugs treated as generic) and a **$9.85** copayment for all other drugs

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
Medicare-covered foot care (podiatry)	**$35** copay	**$65** copay
Medicare-covered chiropractic services	**$20** copay	**40%** of the cost
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**20%** of the cost	**20%** 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		
Occupational and speech therapy Cost share may vary depending on the service and where service is provided.	**$25** copay	**$65** copay or **40%** of the cost

Cardiac rehabilitation Cost share may vary depending on the service and where service is provided.	**$30** copay	**$65** copay or **40%** of the cost
Pulmonary rehabilitation Cost share may vary depending on the service and where service is provided.	**$30** copay	**$65** copay or **40%** of the cost
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered
Specialist	**$35** copay	Not Covered
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

COVID-19 Testing and Treatment

$0 copay for testing and treatment services for COVID-19.

Travel Coverage

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

Humana Well Dine® Meal Program

Humana's meal program for members following an inpatient stay in the hospital or nursing facility.

Over-the-Counter (OTC) mail order

$25 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products.

Rewards and Incentives

Go365 by Humana® a Rewards and Incentive program for completing certain preventive health screenings and health and wellness activities.

SilverSneakers® fitness program

Basic fitness center membership including fitness classes.

Find out **more**

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

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.

Medicare-covered eye refractions during a specialist medical visit are not covered.

Telehealth services shown are in addition to the Original Medicare covered telehealth. Your cost may be different for Original Medicare telehealth.

Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services are for informational purposes only and should not be construed as medical advice. Please refer to your evidence of coverage for additional details on what your plan may cover or other rules that may apply.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

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

Humana®

Humana.com

Notes

Notes

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 their 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'dęę́ niká'adoowoł.

العربية (Arabic)

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