2021

Summary of Benefits

Optional Supplemental Benefits

Humana Gold Choice H8145-004 (PFFS)

North Carolina - Virginia
North Carolina-Virginia

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, 2022.
- ☐ 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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Our service area includes the following county/counties in North Carolina: Anson, Avery, Buncombe, Caswell, Catawba, Cherokee, Davidson, Davie, Forsyth, Gaston, Gates, Henderson, Madison, Mecklenburg, Rowan, Scotland, Watauga, Yancey
Virginia: Alexandria City, Amherst, Appomattox, Bath, Bedford, Bland, Botetourt, Brunswick, Carroll, Chesapeake City, Chesterfield, Craig, Emporia City, Essex, Falls Church City, Floyd, Fredericksburg City, Galax City, Gloucester, Goochland, Greensville, Halifax, Hampton City, Hanover, Harrisonburg City, Henrico, Highland, Isle of Wight, King George, Lancaster, Loudoun, Mecklenburg, Middlesex, Newport News City, Norfolk City, Northampton, Northumberland, Nottoway, Page, Patrick, Petersburg City, Pittsylvania, Portsmouth City, Powhatan, Prince Edward, Pulaski, Radford City, Rappahannock, Richmond, Richmond City, Roanoke, Roanoke City, Rockingham, Salem City, Southampton, Spotsylvania, Stafford, Suffolk City, Virginia Beach City, Westmoreland, Williamsburg City, York.

Let's talk about Humana Gold Choice H8145-004 (PFFS)

Find out more about the Humana Gold Choice H8145-004 (PFFS) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Choice H8145-004 (PFFS) is a Medicare Advantage PFFS plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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

To be eligible

To join Humana Gold Choice H8145-004 (PFFS), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

Humana Gold Choice H8145-004 (PFFS)

How to reach us:

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

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

October 1 - March 31:

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

April 1 - September 30:

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

Or visit our website:
Humana.com/medicare.

More about Humana Gold Choice H8145-004 (PFFS)

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

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

As a member it's a good idea to select a doctor as your Primary Care Provider (PCP). Humana Gold Choice H8145-004 (PFFS) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, you may be subject to higher copayments/coinsurance.

A healthy partnership

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

Monthly Premium, Deductible and Limits

PLAN COSTS		
Monthly plan premium You must keep paying your Medicare Part B premium.	**$86** Depending on your level of Medicaid eligibility, your plan premium may be reduced.	
PLAN COSTS	**IN-NETWORK**	**OUT-OF-NETWORK**
Medical deductible		**$750** out-of-network All services not covered by Original Medicare, Ambulance services, Emergency Room services, Urgently Needed Services at Urgent Care Centers, Immunizations (Flu & Pneumonia), and COVID-19 Tests and Treatment do not apply to the out-of-network deductible.
Pharmacy (Part D) deductible	**$160** for Tier 3, Tier 4, Tier 5	
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for medical services for the year.	**$7,550** combined in- and out-of-network	**$7,550** combined in- and out-of-network

Covered Medical and Hospital Benefits

	IN-NETWORK	**OUT-OF-NETWORK**
ACUTE INPATIENT HOSPITAL CARE		
	$345 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.	**$345** copay per day for days 1-5 **$0** copay per day for days 6-90
OUTPATIENT HOSPITAL COVERAGE		
Outpatient surgery at outpatient hospital	**$345** copay	**$345** copay
Outpatient surgery at ambulatory surgical center	**$295** copay	**$295** copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$20** copay	**$20** copay

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Specialists	**$50** copay	**$50** copay

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 Any additional preventive services approved by Medicare during the contract year will be covered.	**$0** copay Any additional preventive services approved by Medicare during the contract year will be covered.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
EMERGENCY CARE		
Emergency room	**$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.	**$40** copay at an urgent care center	**$40** copay at an urgent care center
OUTPATIENT CARE AND DIAGNOSTIC SERVICES, LABS AND IMAGING Cost share may vary depending on the service and where service is provided		
Diagnostic mammography	**$50** to **$75** copay	**$50** to **$75** copay
Diagnostic radiology	**$180** to **$275** copay	**$180** to **$275** copay
Lab services	**$0** to **$50** copay	**$0** to **$50** copay
Diagnostic tests and procedures	**$0** to **$100** copay	**$0** to **$100** copay
Outpatient X-rays	**$20** to **$110** copay	**$20** to **$110** copay
Radiation therapy	**$50** copay or **20%** of the cost	**$50** copay or **20%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**$50** copay	**$50** copay

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Routine hearing	**HER949** • **$0** copayment for fitting, routine hearing exams up to 1 per year. • **$0** copayment for adjustments up to 2 per year. • **$99** copayment for Advanced level hearing aid up to 1 per ear per year. • **$399** 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.	**HER949** • **$0** copayment for fitting, routine hearing exams up to 1 per year. • **$0** copayment for adjustments up to 2 per year. • **$99** copayment for Advanced level hearing aid up to 1 per ear per year. • **$399** 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.
DENTAL SERVICES The cost-share indicated below is what you pay for the covered service.		
Medicare-covered dental	**$50** copay	**$50** 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	**DEN171** • **$0** copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **$0** copayment for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **$0** copayment for complete dentures, partial dentures up to 1 set(s) every 5 years. • **$0** copayment for panoramic film or diagnostic x-rays, recementation up to 1 every 5 years. • **$0** copayment for bitewing x-rays up to 1 set(s) per year.	**DEN171** • **$0** copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **$0** copayment for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **$0** copayment for complete dentures, partial dentures up to 1 set(s) every 5 years. • **$0** copayment for panoramic film or diagnostic x-rays, recementation up to 1 every 5 years. • **$0** copayment for bitewing x-rays up to 1 set(s) per year.

	IN-NETWORK	OUT-OF-NETWORK
network drop down select HumanaDental Medicare.	• **$0** copayment for adjustments to dentures, denture reline, intraoral x-rays, root canal up to 1 per year. • **$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. • **$0** copayment for periodontal maintenance up to 4 per year. • **$0** copayment for necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. • **$2000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits.	• **$0** copayment for adjustments to dentures, denture reline, intraoral x-rays, root canal up to 1 per year. • **$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. • **$0** copayment for periodontal maintenance up to 4 per year. • **$0** copayment for necessary anesthesia with covered service, simple or surgical extraction up to unlimited 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 Additional vision benefits are available with a separate monthly premium. Please see the "Optional Supplemental Benefits" page for details.		
Medicare-covered vision services	**$50** copay	**$50** copay
Medicare-covered diabetic eye exam	**$0** copay	**$0** copay
Medicare-covered glaucoma screening	**$0** copay	**$0** copay
Medicare-covered eyewear (post-cataract)	**$0** copay	**$0** copay
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$345** copay per day for days 1-4 **$0** copay per day for days 5-90	**$345** copay per day for days 1-4 **$0** copay per day for days 5-90

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Outpatient group and individual therapy visits Cost share may vary depending on where service is provided.	**$40** to **$100** copay	**$40** to **$100** copay
SKILLED NURSING FACILITY (SNF)		
Your plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$184** copay per day for days 21-100	**$0** copay per day for days 1-20 **$184** copay per day for days 21-100
PHYSICAL THERAPY		
Cost share may vary depending on the service and where service is provided.	**$15** to **$40** copay	**$15** to **$40** copay
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		
	$0 copay for up to 24 one-way trips to plan approved locations. Not to exceed 50 miles per trip. The member *must* contact transportation vendor to arrange transportation.	

Prescription Drug Benefits

MEDICARE PART B DRUGS		
Chemotherapy drugs	**20%** of the cost	**20%** 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 **$160** deductible for Tier 3, Tier 4, Tier 5 drugs. You pay the full cost of these drugs until you reach $160. Then, you only pay your cost-share.

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach **$4,130**. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.

Preferred cost-sharing				
Pharmacy options	**Retail** To find the preferred cost-share retail pharmacies near you, go to **Humana.com/pharmacyfinder**		**Mail order** Humana Pharmacy®	
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 1: Preferred Generic	$5	$15	$5	$0
Tier 2: Generic	$15	$45	$15	$0
Tier 3: Preferred Brand	$47	$141	$47	$131
Tier 4: Non-Preferred Drug	$99	$297	$99	$287
Tier 5: Specialty Tier	30%	N/A	30%	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	30%	N/A	30%	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.

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 **$92** depending on your level of Extra Help (for Tier 3, Tier 4, Tier 5). If your deductible is **$92**, you pay the full cost of these drugs until you reach **$92**. 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 **$1.30** copay; or **$3.70** copay ; or **15%** of the cost	**90-day supply** **$0** copay; or **$1.30** copay; or **$3.70** copay ; or **15%** of the cost
For all other drugs, either:	**$0** copay; or **$4** copay; or **$9.20** copay ; or **15%** of the cost	**$0** copay; or **$4** copay; or **$9.20** copay ; or **15%** of the cost

Certain drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

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

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

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

Days' Supply Available

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

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

Coverage Gap

After you enter the coverage gap, you pay **25 percent** of the plan's cost for covered brand name drugs and **25 percent** of the plan's cost for covered generic drugs until your costs total **$6,550** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,550**, you pay the greater of:
- **5%** of the cost, or
- **$3.70** copay for generic (including brand drugs treated as generic) and a **$9.20** copayment for all other drugs

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
Medicare-covered foot care (podiatry)	**$50** copay	**$50** copay
Medicare-covered chiropractic services	**$20** copay	**$20** copay
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**20%** of the cost	**20%** of the cost
Medical Supplies	**20%** of the cost	**20%** of the cost
Prosthetics (artificial limbs or braces)	**20%** of the cost	**20%** 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	**10%** to **20%** of the cost
REHABILITATION SERVICES		
Physical, occupational and speech therapy Cost share may vary depending on the service and where service is provided.	**$15** to **$40** copay	**$15** to **$40** copay
Cardiac rehabilitation	**$15** copay	**$15** copay
Pulmonary rehabilitation	**$15** copay	**$15** copay
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered
Specialist	**$50** 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.

Health Essentials Kit

Kit includes over the counter items useful for preventing the spread of COVID-19 and other viruses.
Limit one per year.

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

$75 every quarter (3 months) for approved select over-the-counter health and wellness products from Humana Pharmacy mail delivery.

SilverSneakers® fitness program

Basic fitness center membership including fitness classes.

Optional **Supplemental Benefits**

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

$15.30

MyOption Vision VIS757

Gives members access to the EyeMed Vision Care Select Network and provides additional vision benefits. These benefits have an additional monthly premium.

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

Find out **more**

You can see our plan's **provider and pharmacy directory** at our website at **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.

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.

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2021

Optional Supplemental Benefits

Humana Gold Choice H8145-004 (PFFS)

North Carolina - Virginia
North Carolina-Virginia

Humana®

My Options, My Choice
Adding Benefits to Your Plan

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

The information in this booklet will tell you about the benefits you can add to your plan. You can add these extra benefits when you sign up for your Medicare Advantage plan. You can also add these benefits after Medicare open enrollment ends on December 7 by contacting your agent or calling OSB sales at 1-888-413-7026. OSB sales is available from 8 a.m. – 8 p.m. local time, seven days a week October 1 – March 31, and Monday through Friday April 1 – September 30.

MyOption℠ Vision (VIS757)

The MyOption℠ Vision benefit helps you plan for your vision care.

Here's how the benefit works:

Monthly Premium	**$15.30**		
Maximum Benefit	Humana pays up to **$375** for one set of eyeglass frames and one pair of lenses **or** contact lenses (conventional or disposable) per calendar year		
Covered Vision Benefits	**In-Network You Pay**	**Out-Of-Network* You Pay**	**Benefit Limitations**
Routine exam with refraction/dilation as necessary - **$40** allowance	Any amount over **$40***	Any amount over **$40**	One per year
$375 (combined in and out-of-network) benefit toward the purchase and fitting of eyeglasses and pair of lenses or contact lenses. Ultraviolet protection and scratch resistant coating are included in the eyeglass allowance benefit. Contact lenses will include conventional or disposable. This benefit can only be used one time per plan year. Any remaining benefit dollars do not "rollover" to a future purchase.	Any amount over **$375** retail price	Any amount over **$375** retail price	One per year

Covered vision services are subject to conditions, limitations, exclusions, and maximums. Please see your

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Evidence of Coverage for details.

*Your routine eye exam charge will not exceed **$40** at an **EyeMed Vision Care Select network optical provider**. Please inform the network provider that you are part of the EyeMed Select Network. When using an out-of-network Vision provider, you will be responsible for costs above the allowance and plan-approved amount. You are responsible for submitting an EyeMed Vision Care out-of-network claim form with itemized receipt when seeing a non-EyeMed select provider. Claim forms can be found on Humana.com or you can call EyeMed Customer service at 1-844-828-8703 Monday thru Saturday 7:30 a.m. – 11 p.m. Eastern Time and Sunday 11 a.m. – 8 p.m. Eastern Time.

The provider locator for routine vision can be found at **Humana.com > Find a Doctor > From the Search Type drop down select Vision > Vision coverage through Medicare Advantage plans**.

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

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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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