2021

Summary of Benefits

Humana Gold Plus SNP-DE H1036-168 (HMO D-SNP)

Greensboro/Winston Salem
Greensboro / Winston-Salem Metro Area

Our service area includes the following county/counties in North Carolina: Alamance, Caswell, Davidson, Davie, Forsyth, Guilford, Person, Randolph, Rockingham, Stokes, Yadkin.

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Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-833-2364 (TTY: 711)**.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit **Humana.com/medicare** or call **1-800-833-2364 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. This plan may enroll dual eligibles who are FBDE, SLMB Plus, QMB Plus and QMB.

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Let's talk about Humana Gold Plus SNP-DE H1036-168 (HMO D-SNP)

Find out more about the Humana Gold Plus SNP-DE H1036-168 (HMO D-SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus SNP-DE H1036-168 (HMO D-SNP) is a Coordinated Care plan with a Medicare contract and a contract with the North Carolina Division of Medical Assistance Medicaid Program. Enrollment in this Humana plan depends on contract renewal.

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

As a member you must select an in-network doctor to act as your Primary Care Provider (PCP). Humana Gold Plus SNP-DE H1036-168 (HMO D-SNP) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services. You have access to Care Managers. Care Managers are nurses or care coordinators who support your health and well-being by providing additional services including: acute and chronic-care management, telephonic and in-person health support; assistance in coordinating Medicare and Medicaid benefits, educational resources and workshops and support for families and caregivers.

To be eligible

To enroll in Humana Gold Plus SNP-DE H1036-168 (HMO D-SNP), a Dual Eligible Special Needs Plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B, live in our service area and also receive certain levels of assistance from the North Carolina Division of Medical Assistance Medicaid Program. If you receive both Medicare and Medicaid benefits, this means you are a dual eligible.

Humana Gold Plus SNP-DE H1036-168 (HMO D-SNP) may enroll dual eligibles who are FBDE, SLMB Plus, QMB Plus and QMB.

Plan name:

Humana Gold Plus SNP-DE H1036-168 (HMO D-SNP)

More about Humana Gold Plus SNP-DE H1036-168 (HMO D-SNP)

As a member of this plan, you will not be responsible for cost sharing for plan benefits. The Comprehensive Benefit Chart shows the benefits you will receive from Humana and how Medicaid covers your cost sharing for those plan benefits. The chart also lists some benefits you could receive from Medicaid if you are eligible for full Medicaid benefits. If you are entitled to Medicaid benefits your care coordinator will work with you to assist you in understanding and accessing the Medicare and Medicaid benefits you may be entitled to.
Be sure to show your Medicaid ID card in addition to your Humana membership card to make your provider aware that you may have additional coverage. Your services are paid first by Humana and then by Medicaid.

How to reach us:

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

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

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

October 1 - March 31:

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

April 1 - September 30:

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

Or visit our website: **Humana.com/medicare**.

For the most current North Carolina Medicaid coverage information, please visit the North Carolina Medicaid website at **http://www.ncdhhs.gov/dma/medicaid/medicare.htm** or call the Medicaid Hotline at 1-800-662-7030 (TTY: 711).

A healthy partnership

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

Monthly Premium, Deductible and Limits

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

Covered Medical and Hospital Benefits

For members protected by North Carolina Medicaid from cost sharing, Medicaid pays coinsurance, copays and deductibles for Original Medicare-covered services. You may be required to pay a small Medicaid copay.

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
ACUTE INPATIENT HOSPITAL CARE		
	$0 copay	
OUTPATIENT HOSPITAL COVERAGE		
Outpatient surgery at outpatient hospital	**$0** copay	**$3** copay for Medicaid-covered services**
Outpatient surgery at ambulatory surgical center	**$0** copay	
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**$3** copay for Medicaid-covered services**
Specialists	**$0** copay	**$3** copay for Medicaid-covered services**
PREVENTIVE CARE		
	Our plan covers many preventive services at no cost when you see an in-network provider including:	**$0** copay for preventive services

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.

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
	• 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.	

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.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
EMERGENCY CARE		
Emergency room If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	**$0** copay	
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$0** copay	
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic mammography	**$0** copay	**$0** copay for Medicaid mammograms
Diagnostic radiology	**$0** copay	
Lab services	**$0** copay	
Diagnostic tests and procedures	**$0** copay	
Outpatient X-rays	**$0** copay	
Radiation therapy	**$0** copay	

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Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
HEARING SERVICES		
Medicare-covered hearing	**$0** copay	
Routine hearing	In-network: **HER945** • **$0** copayment for Advanced level hearing aid up to 1 per ear every 3 years. • **$0** copayment for fitting, routine hearing exams up to 1 every 3 years. • **$0** copayment for adjustments up to 2 every 3 years. • 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.	

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.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
DENTAL SERVICES The cost-share indicated below is what you pay for the covered service.		
Medicare-covered dental	**$0** copay	**$3** copay** (only one copay for services that require more than one visit) • Some services require prior approval
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.	In-network: **DEN181** • **$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. • **$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. • **$2500** maximum benefit coverage amount per year for	

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.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
	preventive and comprehensive benefits.	
VISION SERVICES		
Medicare-covered vision services	**$0** copay	**$0** copay for optical supplies
Medicare-covered diabetic eye exam	**$0** copay	
Medicare-covered glaucoma screening	**$0** copay	
Medicare-covered eyewear (post-cataract)	**$0** copay	
Routine vision 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.	In-network: **VIS734** • **$0** copayment for refraction, routine exam up to 1 per year. • **$100** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglasses include ultraviolet protection and scratch resistant coating.	
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$0** copay	
Outpatient group and individual therapy visits	**$0** copay	**$3** copay for Outpatient Medicaid-covered services**
SKILLED NURSING FACILITY (SNF)		
Your plan covers up to 100 days in a SNF	**$0** copay	Medicaid covers additional days beyond Medicare 100 day limit
PHYSICAL THERAPY		
	$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.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
AMBULANCE		
Ambulance	**$0** copay	
TRANSPORTATION		
	$0 copay for up to 48 one-way trips to plan approved locations. Not to exceed 50 miles per trip. The member *must* contact transportation vendor to arrange transportation.	**$0** copay to Medicaid-covered services

Prescription Drug Benefits

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

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.

Deductible This plan does not have a deductible.

Depending on the level of Extra Help you receive, you'll pay one of the following cost-share amounts each time you fill your drug.

Pharmacy options		
Preferred cost-sharing	**Mail order:** Humana Pharmacy® **Retail:** To find the preferred cost-share retail pharmacies near you, go to **Humana.com/pharmacyfinder**	
Standard cost-sharing	**Mail order:** Walmart Mail **Retail:** All other network retail pharmacies	
For generic drugs (including brand drugs treated as generic), either:	**30-day supply** **$0** copay; or **$1.30** copay; or **$3.70** copay;	**90-day supply** **$0** copay; or **$1.30** copay; or **$3.70** copay;
For all other drugs, either:	**$0** copay; or **$4** copay; or **$9.20** copay;	**$0** copay; or **$4** copay; or **$9.20** copay;

Specialty drugs are limited to a 30 day supply.

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

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

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

Days' Supply Available

Unless otherwise specified, you can get your Part D drug in the following days' supply amounts:

- One month supply (up to 30 days)*
- Two month supply (31-60 days)
- Three month supply (61-90 days)

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

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,550**, you pay nothing for all drugs.

Additional Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
Medicare-covered foot care (podiatry)	**$0** copay	**$3** copay for Medicaid-covered services**
Medicare-covered chiropractic services	**$0** copay	**$2** copay for Medicaid-covered services**
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**$0** copay	
Medical Supplies	**$0** copay	
Prosthetics (artificial limbs or braces)	**$0** copay	Prescription footwear coverage is limited to treatment of diabetics or when shoe is part of a leg brace (orthotic) or if there are foot complications in children under age 21
Diabetic monitoring supplies	**$0** copay	
REHABILITATION SERVICES		
Physical, occupational and speech therapy	**$0** copay	
Cardiac rehabilitation	**$0** copay	
Pulmonary rehabilitation	**$0** copay	
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	
Specialist	**$0** copay	
Urgent care services	**$0** copay	
Substance abuse or behavioral health services	**$0** copay	

Additional Medicaid Covered Services

Dual eligible members who meet financial criteria for full Medicaid coverage may also be eligible to receive Medicaid services not covered by Medicare. Humana Gold Plus SNP-DE H1036-168 (HMO D-SNP) may also offer coverage for these services. The benefits described in the Covered Medical and Hospital Benefits section of the Summary of Benefits above are covered by Medicare. The benefits described below are covered by Medicaid. For each benefit listed below, you can see what North Carolina Medicaid covers and what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility. If you have questions about your Medicaid eligibility and what benefits you are entitled to call North Carolina Medicaid: 1-800-662-7030 (TTY: 711).

BENEFIT	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID STATE PLAN
PRODUCTS AND DEVICES		
Dentures	See "Dental" benefit in the "Covered Medical and Hospital Benefits" chart above	**$0** copay
Eyeglasses	See "Vision" benefit in the "Covered Medical and Hospital Benefits" chart above	**$0** for children **$3** copay for Medicaid vision services** **$2** copay for optical repair over $5** **$2** copay for optical supplies** • Contact lenses covered in special circumstances • Prior approval required for all visual aids
Hearing Aids	See "Hearing" benefit in the "Covered Medical and Hospital Benefits" chart above	**$0** copay if under age 21 • 1 monaural or binaural hearing aid covered with prior approval • Replacements based on medical necessity and require prior approval • Supplies related to hearing aid are covered with prior approval • Batteries are covered No coverage age 21 and older
TRANSPORTATION		
Non-Emergency Medical Transportation Services	See "Transportation" benefit in the "Covered Medical and Hospital Benefits" chart above	**$0** copay • Prior scheduling required

INPATIENT LONG TERM CARE SERVICES		
Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services in Institutions for Mental Diseases (IMD), age 65 and older	Not covered	**$0** copay
Inpatient Psychiatric Services, under age 21	See "Mental Health" benefit in the "Covered Medical and Hospital Benefits" chart above	**$0** copay
Intermediate Care Facility Services for Individuals with Intellectual Disabilities	Not Covered	**$0** copay
Nursing Facility Services, other than in an Institution for Mental Diseases	See "Skilled Nursing" benefit in the "Covered Medical and Hospital Benefits" chart above	**$0** copay
Other Medicaid Covered Services		
Over-the-Counter (OTC) benefit	See "Over-the-Counter benefits" on the "More benefits with your plan" page later in this document	

HOME AND COMMUNITY BASED WAIVER SERVICES

Dual eligible members, who meet the financial criteria for full Medicaid coverage, may also be eligible to receive Waiver services. Waiver services are limited to individuals who meet additional waiver eligibility criteria. For information on waiver services and eligibility, contact North Carolina Medicaid at 1-800-662-7030 (TTY: 711).

**Exemptions. The following categories of recipients are not required to pay a copayment or coinsurance:

(a) Individuals under the age of 21 years.
(b) Pregnant women – for pregnancy – related services, including services for medical conditions that may complicate the pregnancy. This exemption includes the six week period following the end of the pregnancy.
(c) Individuals receiving services in an inpatient hospital setting, long-term care facility, or other medical institution if, as a condition of receiving services in the institution, that individual is required to spend all of his or her income for medical care costs with the exception of the minimal amount required for personal needs.
(d) Individuals who require emergency services after the sudden onset of a medical condition which, if left untreated, would place their health in serious jeopardy.
(e) Individuals receiving services or supplies related to family planning.

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

The Medicaid information included in this section is current as of 7/1/2020. All Medicaid covered services are subject to change at any time. For the most current North Carolina Medicaid coverage information, please visit the North Carolina Medicaid website at **http://www.ncdhhs.gov/dma/medicaid/medicare.htm** or call the Medicaid Hotline at 1-800-662-7030 (TTY: 711).

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.

Healthy Foods Card

$75 every month to spend at participating retailers toward the purchase of approved healthy food.

Chiropractic services

Routine chiropractic:
$0 copay per visit for up to 12 visits

Smoking cessation program

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

Routine foot care

$0 copay per visit for up to 6 visits

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

$200 every quarter (3 months) for approved select over-the-counter health and wellness products from Humana Pharmacy mail delivery.

Personal Emergency Response System

The personal emergency response system provides help in emergency situations. The medical alert service comes with an installed in-home communication device and a wearable button. You have the choice between a push button unit (with or without AutoAlert fall detection) or a wrist unit (without AutoAlert).

Personal Home Care

$0 copayment for a minimum of 3 hours per day, up to a maximum of 78 hours per year for certain in-home services to assist individuals with disabilities and/or medical conditions in performing activities of daily living (ADLs) within the home by a qualified aide (e.g., assistance with bathing, dressing, toileting, walking, eating, and preparing meals).

Authorization may be required. Contact the plan for details.

Wigs (related to chemotherapy treatment)

Up to a **$500** maximum benefit per year.

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.

Humana has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2023 based on a review of Humana's Model of Care.

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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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)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

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