2027

Summary of Benefits

Humana Dual Select H4939-002 (HMO-POS D-SNP)

Indiana

Our service area includes the following county/counties in Indiana: Adams, Allen, Bartholomew, Benton, Blackford, Boone, Brown, Carroll, Cass, Clark, Clay, Clinton, Crawford, Daviess, Dearborn, Decatur, DeKalb, Delaware, Dubois, Elkhart, Fayette, Floyd, Fountain, Franklin, Fulton, Gibson, Grant, Greene, Hamilton, Hancock, Harrison, Hendricks, Henry, Howard, Huntington, Jackson, Jasper, Jay, Jefferson, Jennings, Johnson, Knox, Kosciusko, La Porte, Lagrange, Lake, Lawrence, Madison, Marion, Marshall, Martin, Miami, Monroe, Montgomery, Morgan, Newton, Noble, Ohio, Orange, Owen, Parke, Perry, Pike, Porter, Posey, Pulaski, Putnam, Randolph, Ripley, Rush, Scott, Shelby, Spencer, St. Joseph, Starke, Steuben, Sullivan, Switzerland, Tippecanoe, Tipton, Union, Vanderburgh, Vermillion, Vigo, Wabash, Warren, Warrick, Washington, Wayne, Wells, White, Whitley.

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 **888-873-0686 (TTY: 711)**.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **Humana.com/medicare** or call **888-873-0686 (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.
- ☐ Review the formulary (Drug Guide) to make sure your drugs are covered.

Understanding Important Rules

- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month. The Part A/Part B premiums may be paid for by Indiana Medicaid.
- ☐ Benefits, premiums and/or copays/coinsurance may change on January 1, 2028.
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ This plan allows you to see dental providers outside of our network (non-contracted providers). However, while we will pay for certain covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copay/coinsurance for services received by non-contracted providers.
- ☐ 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 QDWI, QI, QMB, SLMB.



Let's talk about Humana Dual Select H4939-002 (HMO-POS D-SNP)

Find out more about the Humana Dual Select H4939-002 (HMO-POS D-SNP) plan – including the health and drug services it covers – in this easy-to-use booklet.

Humana Dual Select H4939-002 (HMO-POS D-SNP) is a Dual Eligible Special Needs plan with a Medicare contract and a contract with Indiana 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, please refer to the plan's Evidence of Coverage on our website, **Humana.com/PlanInformation.**

As a member you must select an in-network doctor within the service area listed in this booklet to act as your Primary Care Provider (PCP). Humana Dual Select H4939-002 (HMO-POS D-SNP) has a network of doctors, hospitals, pharmacies and other providers. This plan includes a point-of-service feature for certain covered services; however, not all out-of-network services are covered. If you use providers who aren't in our network, the plan may not pay for these services unless the service is covered under the plan's out-of-network or point-of-service rules, or another exception applies.

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

If you receive both Medicare and Medicaid benefits, this means you are dual eligible. To enroll in Humana Dual Select H4939-002 (HMO-POS 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 Indiana Medicaid.

Humana Dual Select H4939-002 (HMO-POS D-SNP) may enroll QDWI, QI, QMB, SLMB.

Qualified Disabled and Working Individual (QDWI): Helps pay Part A premiums.

Qualifying Individual (QI): Helps pay Part B premiums.

Qualified Medicare Beneficiary (QMB): Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).

Specified Low-Income Medicare Beneficiary (SLMB): Helps pay Part B premiums.

Plan name

Humana Dual Select H4939-002 (HMO-POS D-SNP)

Humana.

More about Humana Dual Select H4939-002 (HMO-POS D-SNP)

Depending on your level of eligibility for assistance under your state Medicaid program, you may or may not be subject to cost-sharing requirements. The Medicaid Benefit Comparison chart shows specific benefits that Medicaid may cover for some dual eligible members. You will work with your Humana care coordinator to understand and access these benefits. The Covered Medical and Hospital Benefits chart shows the benefits you will receive from Humana.

Be sure to show the Indiana Medicaid ID card in addition to your Humana membership card to make your provider aware that you also have Medicaid coverage. You may be required to pay a small Medicaid specific co-payment. 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 Indiana Medicaid for further details.

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

If you're **not** a member of this plan, call toll free: **888-873-0686 (TTY: 711)**.

You can call us seven days a week from 8 a.m. to 8 p.m. Please note that our automated phone system may answer your call during weekends and holidays.

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

Medicaid benefits last validated on 07/01/2026 and are subject to change. For the most current Indiana Medicaid coverage information, please visit Indiana Medicaid website at **https://www.in.gov/medicaid/** or call the Medicaid Hotline at 800-457-4584 (toll free) .

A healthy partnership

Get more from this 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. Your Part A and/or Part B premium may be paid on your behalf by Indiana Medicaid Program.
Medical deductible * You pay the same amount as you would with Original Medicare.	**$0** or **$292*** for in-network Part B services, depending on your level of Medicaid eligibility. The following services listed are excluded from the in-network deductible: Ambulance Services Chemotherapy Drugs and Administration Continuous Glucose Monitor Diabetic Monitoring Supplies Diagnostic Colonoscopy Diagnostic Mammography Durable Medical Equipment Emergency Room Services Medicare Covered Preventive Services Medicare Part B Insulin Drugs Other Medicare Part B Drugs Outpatient Blood Services Part A Services (Home Health, Inpatient, and Skilled Nursing) Urgently Needed Services at Urgent Care Centers Services not covered by Original Medicare (i.e., Supplemental Benefits)
Pharmacy (Part D) deductible	If you receive Extra Help, this plan has a **$0** deductible. If you do not receive Extra Help, your plan has a **$150** deductible for Tier 3, Tier 4 and Tier 5 drugs. Refer to the Prescription Drug Benefits section below.
Medical Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for covered medical services for the year	**$9,850** in-network If you are eligible for Medicare cost-sharing assistance under Indiana Medicaid you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: ***Humana.com/PAL****.*

Humana.

Medical Benefits

Note: Cost sharing is based on your level of Medicaid eligibility. For this plan, the following Medicaid levels are cost-share protected: QMB.

	WHAT YOU PAY ON THIS HUMANA PLAN
INPATIENT HOSPITAL COVERAGE	
This plan covers an unlimited number of days for an inpatient stay.	**$0** or **$2,241** copay per admit
OUTPATIENT HOSPITAL COVERAGE	
Diagnostic colonoscopy	**$0** copay
Diagnostic mammography	**$0** copay
Surgery services	**$0** or **20%** of the cost
AMBULATORY SURGERY CENTER	
Diagnostic colonoscopy	**$0** copay
Surgery services	**$0** or **20%** of the cost
DOCTOR VISITS	
Primary care provider (PCP)	
• PCP's office	**$0** copay
• Telehealth	**$0** copay
Specialist	
• Specialist's office	**$0** or **20%** of the cost
• Telehealth	**$0** or **20%** of the cost
PREVENTIVE CARE	
This plan covers all Medicare preventive services including:	**$0** copay
Cancer Screenings	
• Breast cancer screening (mammogram)	
• Cervical and vaginal cancer screening	
• Colorectal cancer screening	
• Lung cancer screening	
• Prostate cancer screening	
Cardiovascular (heart) Care	
• Abdominal aortic aneurysm screening	
• Cardiovascular disease risk reduction visit	
• Cardiovascular disease screenings	

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: ***Humana.com/PAL****.*

Medical Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
Diabetes Care • Diabetes screenings • Diabetes self-management training • Medicare Diabetes Prevention Program (MDPP)	
Dietary Guidance and Support • Medical nutrition therapy • Obesity screening and therapy	
Routine Screenings and Immunizations • Annual Wellness Visit (AWV) • Immunizations • Routine physical exam • "Welcome to Medicare" preventive visit	
Screenings and Counseling Services • Bone mass measurement • Depression screening • Glaucoma screening • HIV screening • Screening & counseling to reduce alcohol misuse • Sexually transmitted infections (STIs) screening and counseling • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Any additional preventive services approved by Medicare during the contract year will be covered.	
EMERGENCY CARE	
Emergency room If you are admitted to the same hospital within 24 hours for the same condition, you pay $0 for the emergency care you received.	**$0** or **$115** copay
URGENTLY NEEDED SERVICES	
• **Telehealth** • **Urgent care center** Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$0** or **20%** of the cost **$0** or **20%** of the cost

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: ***Humana.com/PAL****.*

Humana.

Medical Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
WORLDWIDE COVERAGE	
• **Emergency ambulance**	**$0** or **$325** copay per date of service
• **Emergency room - Hospital**	**$0** or **$115** copay
• **Urgent care center**	**$0** or **20%** of the cost
If you have an emergency or urgently needed service outside of the U.S and its territories, you will be responsible to pay for the rendered services upfront and can request reimbursement. If you are admitted to the same hospital within 24 hours for the same condition, you pay $0 for the emergency care you received.	
DIAGNOSTIC SERVICES, LABS AND IMAGING	
Advanced imaging services (MRI, MRA, PET and CT scans)	
• Freestanding radiological facility	**$0** or **$205** copay
• Outpatient hospital	**$0** or **$345** copay
• PCP's office	**$0** or **$330** copay
• Specialist's office	**$0** or **$330** copay
Basic radiological services (X-rays)	
• Freestanding radiological facility	**$0** or **20%** of the cost
• Outpatient hospital	**$0** or **20%** of the cost
• PCP's office	**$0** copay
• Specialist's office	**$0** or **20%** of the cost
• Urgent care center	**$0** or **20%** of the cost
Diagnostic mammography	
• Freestanding radiological facility	**$0** copay
• Specialist's office	**$0** copay
Diagnostic procedures and tests	
• Outpatient hospital	**$0** or **20%** of the cost
• PCP's office	**$0** copay
• Specialist's office	**$0** or **20%** of the cost
• Urgent care center	**$0** or **20%** of the cost
Lab services	
• Freestanding laboratory	**$0** copay
• Outpatient hospital	**$0** copay
• PCP's office	**$0** copay
• Specialist's office	**$0** copay
• Urgent care center	**$0** copay

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: ***Humana.com/PAL****.*

Medical Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
Nuclear medicine and services	
• Freestanding radiological facility	**$0** or **20%** of the cost
• Outpatient hospital	**$0** or **20%** of the cost
Sleep study	
• Member's home	**$0** copay
• Outpatient hospital	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
Therapeutic radiology (Radiation therapy)	
• Freestanding radiological facility	**$0** or **20%** of the cost
• Outpatient hospital	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost

HEARING SERVICES

Medicare-covered hearing	**$0** or **20%** of the cost
Mandatory supplemental hearing benefit	**HER101** • **$0** copay for routine hearing exams up to 1 per year. • **$0** copay for fitting up to 1 per year. • **$0** copay for follow-up provider visits up to 3 per year. • **$0** copay for each Level 2 prescription hearing aid up to 1 per ear per year. • Note: Includes 3 years of batteries per non-rechargeable aid (up to 60 cells per ear, per year) and 3 year warranty. • One fitting and three follow-up provider visits during first year following hearing aid purchase, with the original provider.

DENTAL SERVICES

Medicare-covered dental	**$0** or **20%** of the cost
Mandatory supplemental dental benefit Limitations and exclusions may apply. Please see your Evidence of Coverage (EOC) for additional details.	**DEN382** • **$0** copay for amalgam and/or composite filling up to 1 per tooth per surface every 2 years. • **$0** copay for crown recementation up to 1 every 2 years. • **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: ***Humana.com/PAL****.*

Humana.

WHAT YOU PAY ON THIS HUMANA PLAN

Benefit Limits

- Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage.
- Dental benefits under this plan may not cover all ADA procedure codes. Any services received that are not listed will not be covered by the plan and will be the member's responsibility.
- The member is responsible for any amount above the annual maximum benefit coverage amount.
- Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. Information regarding each plan is available at **Humana.com/sb**.

In-network providers

- In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS).
- If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule (but any applicable coinsurance payment still applies).

Out-of-network providers

- Out-of-network dentists have not agreed to provide services at contracted fees.
- The out-of-network provider may bill the member for more than what the plan pays, even for services listed with no member cost share. Members are responsible for this difference between Humana's reimbursement and the out-of-network provider's charges. This is known as balance billing.
- Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions.
- Members may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Please see above for provider locator instructions. Network providers agree to bill us directly.

- **$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment up to 1 every 3 years.
- **$0** copay for crown, other restorative services - core buildup and prefabricated post and core up to 1 per tooth every 5 years.
- **$0** copay for bridges-pontic, panoramic film or diagnostic x-rays up to 1 every 5 years.
- **$0** copay for bridges-crown up to 2 every 5 years.
- **$0** copay per tooth for root canal, root canal retreatment, simple or surgical extraction up to 1 per lifetime.
- **$0** copay for necessary nitrous oxide/analgesia with covered service up to 1 unit(s) per visit.
- **$0** copay for bitewing x-rays, bridge recementation, scaling for moderate inflammation up to 1 per year.
- **$0** copay for emergency diagnostic exam, emergency treatment for pain, necessary general anesthesia with covered service, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.
- **$0** copay for periodontal maintenance up to 4 per year.
- **$0** copay for intraoral x-rays up to 6 per year.
- **$0** copay for necessary incremental anesthesia with covered service up to as needed with covered codes per year.
- **$2,500** combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: ***Humana.com/PAL****.*

Medical Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
• If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement. The coinsurance level will apply to the average negotiated in-network fee schedule (INFS) in your area. • See Chapter 2 Payment Requests Contact Information in your Evidence of Coverage or visit **Humana.com** for information on requesting reimbursement.	
VISION SERVICES	
Eyewear (post cataract surgery)	**$0** or **20%** of the cost
Medicare-covered diabetic eye exam	**$0** copay
Medicare-covered vision services The provider locator for Medicare-covered vision can be found at **Humana.com/FindCare**.	**$0** or **20%** of the cost
Mandatory supplemental vision benefit Please inform the network provider that you are part of the Humana Medicare Insight Network. NOTE: The network of providers for your supplemental vision benefits through Humana Medicare Insight Network may be different than the network of providers for the Medicare-covered vision benefits. The mandatory supplemental vision benefits are provided through the Humana Medicare Insight Network. The provider locator can be found at **Humana.com/FindCare**. Benefit is applied toward the retail price. Member is responsible for any costs above the plan approved amount. Lost or broken materials are not covered. This benefit is limited to a one-time use per year. Any remaining benefit dollars do not "roll over" to a future purchase. Eyeglass lens options may be available with the maximum benefit coverage amount up to one pair per year. Benefits are offered on a calendar basis. Any amount unused by the end of the year will expire.	**VIS736** • **$0** copay for routine exam up to 1 per year. • **$50** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • OR • **$100** maximum benefit coverage amount per year at PLUS Provider 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. • Maximum benefit coverage amounts cannot be combined. PLUS providers are part of the Humana Medicare Insight Network and are indicated in the provider locator search results.

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: ***Humana.com/PAL****.*

Humana.

Medical Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
Copayments, coinsurances, and deductibles paid for supplemental benefits do not count toward your maximum out-of-pocket amount.	
MENTAL HEALTH SERVICES	
Inpatient This plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$0** or **$2,091** copay per admit
Mental health therapy visits	
• Outpatient hospital	**$0** or **$35** copay
• Specialist's office	**$0** or **$35** copay
• Telehealth	**$0** or **$35** copay
Outpatient substance abuse services	
• Outpatient hospital	**$0** or **$35** copay
• Specialist's office	**$0** or **$35** copay
• Telehealth	**$0** or **$35** copay
SKILLED NURSING FACILITY (SNF)	
This plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$0** or **$221** copay per day for days 21-100
AMBULANCE	
• **Air**	**$0** or **$1800** copay per date of service
• **Ground**	**$0** or **$325** copay per date of service
TRANSPORTATION	
Mandatory supplemental transportation benefit The member ***must*** contact transportation vendor at least 3 business days in advance of their appointment to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider.	**$0** copay for plan approved location up to 24 one-way trip(s) per year. This benefit is not to exceed 25 miles per one-way trip.
Uniformity flexibility non-emergency medical transportation benefit The member ***must*** contact transportation vendor at least 3 business days in advance of their appointment to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider.	**$0** copayment for plan approved location up to unlimited one-way trip(s) per year for members with a Chronic Kidney Disease (CKD), End Stage Renal Disease (ESRD), or Cancer Diagnosis. This benefit is not to exceed 25 miles per one-way trip.

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: ***Humana.com/PAL****.*

Medical Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
MEDICARE PART B DRUGS Some rebatable Part B drugs may be subject to a lower coinsurance.	
Allergy shots and serum	
• PCP's office	**$0** copay
• Specialist's office	**$0** copay
Chemotherapy drugs	
• Outpatient hospital	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
Other Part B drugs	
• Outpatient hospital	**$0** or **20%** of the cost
• PCP's office	**$0** or **20%** of the cost
• Pharmacy	**$0** copay
• Specialist's office	**$0** or **20%** of the cost
Part B Insulin	
• Outpatient hospital	**$0** or **20%** of the cost
• PCP's office	**$0** or **20%** of the cost
• Pharmacy	**$0** copay
• Specialist's office	**$0** or **20%** of the cost
You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan.	

Prescription Drug Benefits

PLAN HIGHLIGHTS	
Extra Help	Most of our members qualify for and are getting Extra Help from Medicare to pay for their prescription drug plan costs. If you are in the Extra Help program, please refer to the Extra Help section below to view your deductible and Initial Coverage Stage cost shares.
100-day supply	Up to 100-day supply on eligible drugs
Insulin costs	You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan.
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: ***Humana.com/PAL****.*

Humana.

EXTRA HELP

If you receive Extra Help for your drugs, you will have a **$0** deductible.

Prior to reaching your annual **$2,400** out-of-pocket limit, you will pay one of the following depending on your level of Extra Help:

- **$5.80** for generic/preferred multi-source drug or biosimilar; **$14.40** for any other drug; OR
- **$1.65** for generic/preferred multi-source drug or biosimilar; **$5.00** for any other drug; OR
- **$0** for all drugs

After reaching your annual **$2,400** out-of-pocket limit, you will pay **$0** for the remainder of the calendar year, regardless of the level of Extra Help you receive. Additional information will be available on your LIS rider.

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 800-772-1213 (TTY: 800-325-0778), Monday – Friday, 7 a.m. – 7 p.m. For more information on your prescription drug benefit, please call us or access your Evidence of Coverage online.

DEDUCTIBLE

This plan has a **$150** deductible for Tier 3, Tier 4 and Tier 5 drugs. You pay the full cost of these drugs until you reach **$150**. Then, you only pay your cost-share, entering into the Initial Coverage Stage.

INITIAL COVERAGE

You pay the following until your total out-of-pocket costs reach **$2,400**. Once you reach this amount, you will enter the Catastrophic Stage.

Pharmacy Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		**Standard Mail-Order Cost-Sharing**		**Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy®	
Day supply	**30-day**	**100-day***	**30-day**	**100-day***	**30-day**	**100-day***
Tier 1: Preferred Generic	$0	$0	$10	$30	$0	$0
Tier 2: Generic	$0	$0	$20	$60	$0	$0
Tier 3: Preferred Brand	25%	25%	25%	25%	25%	25%
Tier 4: Non-Preferred Drug	25%	25%	25%	25%	25%	25%
Tier 5: Specialty Tier	31%	N/A	31%	N/A	31%	N/A

To find which pharmacies are available in our network, go to **Humana.com/pharmacyfinder**.

*Some drugs are limited to a 30-day supply and others may be eligible for up to a 100-day supply.

Insulin Cost-Sharing						
	Retail Cost-Sharing Includes all in-network retail pharmacies		**Standard Mail-Order Cost-Sharing**		**Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy®	
Day supply	**30-day**	**100-day***	**30-day**	**100-day***	**30-day**	**100-day***
Tier 1: Preferred Generic	$0	$0	25% up to $10	25% up to $30	$0	$0
Tier 2: Generic	$0	$0	24% up to $20	24% up to $60	$0	$0
Tier 3: Preferred Brand	25% up to $35	25% up to $105	25% up to $35	25% up to $105	25% up to $35	25% up to $105
Tier 4: Non-Preferred Drug	25% up to $35	25% up to $105	25% up to $35	25% up to $105	25% up to $35	25% up to $105
Tier 5: Specialty Tier	25% up to $35	N/A	25% up to $35	N/A	25% up to $35	N/A

*Not all tiers may include insulin. Please refer to your Prescription Drug Guide to confirm insulin coverage.

You can fill your prescriptions in several ways, including through retail and mail-order pharmacies. For Humana plans, CenterWell Pharmacy® is the preferred mail-order pharmacy with cost-sharing benefits. To learn more, visit **CenterWellPharmacy.com**.

You won't pay more than **$35** for a one-month (up to 30-day) supply of each plan-covered insulin product regardless of cost-sharing tier, even if you haven't paid your deductible.

To find which pharmacies are available in our network, go to **Humana.com/pharmacyfinder**.

*Some drugs are limited to a 30-day supply and others may be eligible for up to a 100-day supply.

CATASTROPHIC COVERAGE

After your total out-of-pocket costs reach **$2,400** you pay **$0** for plan-covered Part D drugs.

If you reside at an in-network long-term care facility, you pay the same as you would at an in-network retail pharmacy. Under certain situations you may be able to get drugs from an out-of-network pharmacy but may pay more than you would pay at an in-network pharmacy.

Humana.

Additional benefits

	WHAT YOU PAY ON THIS HUMANA PLAN
Acupuncture services (Medicare-covered)	**$0** or **20%** coinsurance for acupuncture for chronic low back pain visits up to 20 visit(s) per year.
Chiropractic services (Medicare-covered)	**$0** or **$15** copay
Podiatry services (Medicare-covered)	**$0** or **20%** of the cost
MEDICAL EQUIPMENT/SUPPLIES	
Continuous glucose monitor (CGM)	
• DME provider	**$0** copay
• Pharmacy	**$0** copay
• Preferred pharmacy	**$0** copay
Diabetic monitoring supplies	
• Diabetic supplier	**$0** or **20%** of the cost
• Network retail pharmacy	**$0** copay
• Preferred diabetic supplier	**$0** copay
Durable medical equipment (DME)	**$0** or **20%** of the cost
Medical supplies at medical supplier	**$0** or **20%** of the cost
Prosthetic devices and related supplies	**$0** or **20%** of the cost
REHABILITATION SERVICES	
Cardiac rehabilitation services	
• Outpatient hospital	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
Occupational therapy	
• Comprehensive outpatient rehab facility	**$0** or **20%** of the cost
• Outpatient hospital	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
Physical therapy	
• Comprehensive outpatient rehab facility	**$0** or **20%** of the cost
• Outpatient hospital	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
Pulmonary rehabilitation services	
• Outpatient hospital	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
Speech therapy	
• Comprehensive outpatient rehab facility	**$0** or **20%** of the cost
• Outpatient hospital	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: ***Humana.com/PAL****.*

Additional benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)	
• Outpatient hospital	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost

Medicaid Benefit Comparison

The benefits described in the Covered Medical and Hospital Benefits sections above are covered by Humana Dual Select H4939-002 (HMO-POS D-SNP). For each benefit listed below, you can see what Indiana Medicaid covers and what this plan covers.

All Medicaid benefits are subject to Indiana Medicaid eligibility guidelines and requirements and are available only to full dual eligible individuals. If you have questions about your Medicaid eligibility and what benefits you are entitled to, review your member handbook or contact Indiana Medicaid at 800-457-4584 (toll free).

BENEFIT	MEDICAID BENEFIT	THIS PLAN BENEFIT
Ambulance	Not Covered	Covered
Ambulatory surgical center	Not Covered	Covered
Diagnostic services, labs, and imaging	Not Covered	Covered
Doctor visits	Not Covered	Covered
Emergency care	Not Covered	Covered
Eyeglasses	Not Covered	Covered
Hearing aids	Not Covered	Covered
Inpatient hospital	Not Covered	Covered
Inpatient mental health services, nursing facility and intermediate care facility services in institutions for mental diseases (MD), age 65 and older	Not Covered	Covered with limitations
Inpatient mental health services, under age 21	Not Covered	Covered with limitations
Medicare Part B drugs	Not Covered	Covered
Mental health services	Not Covered	Covered

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: ***Humana.com/PAL****.*

Humana.

BENEFIT	MEDICAID BENEFIT	THIS PLAN BENEFIT
Nursing facility services, other than in an institution for mental diseases	Not Covered	Covered with limitations
Outpatient hospital coverage	Not Covered	Covered
Physical, occupational, speech therapy	Not Covered	Covered
Preventive care	Not Covered	Covered
Skilled nursing facility	Not Covered	Covered
Transportation	Not Covered	Covered
Urgently needed services	Not Covered	Covered

More benefits with this plan

Enjoy some of these extra benefits included in this plan.
This is a summary of what we cover. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of coverage and services. Visit **Humana.com/PlanInformation** to view a copy of the EOC or call **888-873-0686**.

Humana Healthy Options Allowance®*

$115 monthly allowance on a prepaid spending card.

All plan members receive this amount to buy approved over the counter (OTC) health and wellness products at participating retailers or through the plan's approved OTC mail order vendor.

Plus, members may also use this money for eligible groceries, utilities, rent, and more if they have certain qualifying chronic condition(s) and meet other program criteria.

Any unused amount rolls over each month and expires at the end of the plan year or upon disenrollment, whichever occurs first.

- Allowance is available to use at the beginning of every month.
- Limitations and restrictions may apply.

HMO Travel Benefit

Members may receive in-network benefits when services are received from a participating HMO National Network provider when traveling to other states.

You must select an in-network doctor within the service area listed in this booklet to act as your Primary Care Provider (PCP).

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 attempts 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.

Humana Well Dine® Meal Program

$0 copayment for Humana Well Dine® meal program.

After your inpatient stay in either a hospital or a nursing facility, you may be eligible to receive 2 home delivered meals per day for 7 days (up to 14 meals).

* This spending allowance is a Special supplemental benefit(s) for members with specific chronic conditions who require intensive care coordination and are at a high risk for hospitalization or other adverse health outcomes. Qualifying conditions may include diabetes mellitus, cardiovascular disorders, chronic and disabling mental health conditions, chronic lung disorders, or chronic heart failure, among others. Some plans require at least two conditions. See the plan's Evidence of Coverage for details. If you use this program for rent or utilities, Housing and Urban Development (HUD) requires it to be reported as income. Contact your local HUD office with questions.

Humana.

Meals must be requested within 30 days of discharge from your inpatient stay.

Limited to 4 times per year.

Rewards and Incentives - Go365® by Humana
Complete eligible healthy activities, like preventive screenings and exams, and get rewarded with Go365 Advanced.

SilverSneakers® fitness program
$0 copayment for SilverSneakers®.

The fitness program includes access to participating locations and signature group exercise classes led by certified instructors.

This benefit also connects you to a support network and virtual resources through live classes, on-demand videos and through a mobile app.

Go to SilverSneakers.com to learn more about your benefit.

Find out **more**

Need help finding a doctor or pharmacy? You can see this plan's **Provider and Pharmacy Directory** at our website at **Humana.com/FindCare** or call us at the number listed at the beginning of this booklet and we will send you one. Many doctor listings include a Care Highlight® rating. These ratings in clinical quality and cost-efficiency can help you make informed choices about your healthcare. Ratings only appear when we have enough information to measure a doctor's clinical quality and cost-efficiency. Learn more at **Humana.com/CareHighlight**.

You can see this plan's **Drug Guide** at our website at **Humana.com/druglist** or call us at the number listed at the beginning of this booklet and we will send you one.

Clinical quality and cost-efficiency ratings are available in all states except Alaska. Ratings are not available for all physicians. Care Highlight is intended for informational purposes only. Members have access to all physicians in the Humana network, regardless of whether or not the physician has a Care Highlight rating. Ratings should not be the sole basis for selecting a doctor. Humana does not give performance-based payments to doctors based on these ratings. Ratings do not guarantee the quality or outcome of healthcare services.

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 Dual Select H4939-002 (HMO-POS D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until December 31, 2028 based on a review of the Humana Dual Select H4939-002 (HMO-POS D-SNP) Model of Care.

If you get Medicare cost-share assistance, Humana Dual Select H4939-002 (HMO-POS D-SNP) providers aren't allowed to collect or bill you for services and items covered under Medicare Part A and Part B, including deductibles, coinsurance, and copayments – even when Medicaid payment is zero or a provider chooses to not submit to Medicaid. If a provider asks you to pay, that's against the law. You may however be responsible for a small Medicaid copayment.

If you are billed or asked to pay an in-network provider for deductibles, coinsurance, or copayments on covered Medicare Part A and Part B services, tell your provider you are cost-share protected and can't be charged. If you have already made payment, you have the right to a refund. If your provider will not stop billing, you can call us at 800-457-4708 or you can call Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048). Humana or Medicare can ask your provider to stop billing you and refund any payment you have made.

Your provider may choose to submit to Indiana Medicaid for consideration of additional secondary payment for an amount applied to deductibles, coinsurance, or copayments. If you are cost-share protected,

Humana.

providers are required by federal regulation to accept Humana Dual Select H4939-002 (HMO-POS D-SNP) primary payment and Indiana Medicaid secondary payment as payment in full for covered Medicare Part A and Part B services – even when the Medicaid payment is zero or a provider chooses to not submit to Medicaid.

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 this plan may cover or other rules that may apply.

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

All product names, logos, brands and trademarks are property of their respective owners, and any use does not imply endorsement.

More information is just a click away.

Visit **Humana.com/PlanInformation** to see additional details about this plan, including benefits and costs.

If you'd like a printed Evidence of Coverage, Provider Directory, or Drug Guide mailed to you, you can request one online at the website above, or call **800-457-4708 (TTY: 711)**, 24 hours a day, seven days a week. Please have your Humana member ID card ready when you call. When asked for the reason you've called, say "Evidence of Coverage," "Drug Guide" or "Provider Directory."

Activate your secure MyHumana account.

Your online MyHumana account is an important part of your Humana membership. Use it to view this plan's details anytime and access important plan documents online, all in one place. It's easy to use and tailored to you.

Already have an account?

Go to **Humana.com/Member/ManageYourAccount** and log in.

Don't have an account yet?

Create one using the same link above in just minutes.

Receiving information about other insurance products

As a Humana member, we may call you to offer other insurance-related products. You can opt out of any future calls using the Customer Care number on the back of your ID card.

Humana.

Notice of Non-Discrimination

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Humana Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).

- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

- U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019, 800-537-7697 (TDD)**.

This notice is available at **www.humana.com/legal/non-discrimination-disclosure**.

GHHNDN2026HUM_0526

Notice of Availability - Auxiliary Aids and Services Notice

H4939002000

English: Free language, auxiliary aid, and alternate format services are available. Call **877-320-1235 (TTY: 711)**.

አማርኛ [Amharic]፡-ነፃ ቋንቋ፣ አጋዥ ማዳመጫ፣ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችም ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسيق البديل مجاناً. اتصل على الرقم **877-320-1235 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք **877-320-1235 (TTY՝ 711)** հեռախոսահամարով:

Bǎsɔ́ɔ̀ [Bassa]: Wuɖu-xwíníín-mú-zà-zà kǜà, hwòɖǒ-fɔ́nɔ́-nyɔ̀,, kè nyɔ-ɓɔ̌-po-kà ɓě ɓɛ́ wa nyuɛsé wíɖí pɛ́ɛ̀-pɛ́ɛ̀ɖò kɔ.̌ Ðá **877-320-1235 (TTY: 711)**.

বাংলা [Bengali]: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **877-320-1235 (TTY: 711)** নম্বরে।

简体中文 [Simplified Chinese]：我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 **877-320-1235**（听障专线：**711**）。

繁體中文 [Traditional Chinese]：我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 **877-320-1235**（聽障專線：**711**）。

Kreyòl Ayisyen [Haitian Creole]: Gen sèvis lengwistik gratis, èd oksilyè, ak lòt fòma sèvis ki disponib. Rele **877-320-1235 (TTY: 711).**

Hrvatski [Croatian]: Dostupne su besplatne jezične usluge, usluge dodatne pomoći i alternativnog formata. Nazovite **877-320-1235 (TTY: 711)**.

فارسی [Farsi] : خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **877-320-1235 (TTY: 711)** تماس بگیرید.

Français [French]: Des services gratuits d'assistance linguistique, d'aide auxiliaire et de format alternatif sont disponibles. Appelez le **877-320-1235 (ATS : 711)**.

Deutsch [German]: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **877-320-1235 (TTY: 711)**.

Ελληνικά [Greek]: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **877-320-1235 (TTY: 711)**.

ગુજરાતી [Gujarati] : મફત ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **877-320-1235 (TTY: 711)** પર કૉલ કરો.

עברית [Hebrew]: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **877-320-1235 (TTY: 711)**

हिंदी [Hindi]: निःशुल्क भाषा, सहायक मदद और वैकल्पिक प्रारूप सेवाएं उपलब्ध हैं। **877-320-1235 (TTY:711)** पर कॉल करें।

Hmoob [Hmong]: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **877-320-1235 (TTY: 711)**.

Bekee [Igbo]: Asụsụ n'efu, enyemaka nkwarụ, na ọrụ usoro ndị ọzọ dị. Kpọọ **877-320-1235 (TTY: 711)**.

GHHNOA2026HUM_0526

Italiano [Italian]: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiamare il numero **877-320-1235 (TTY: 711)**.

日本語 [Japanese]:言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。**877-320-1235 (TTY: 711)** までお電話ください。

ភាសាខ្មែរ [Khmer]៖ សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបានฯ ទូរសព្ទទៅលេខ **877-320-1235 (TTY: 711)** ฯ

한국어 [Korean]: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다. **877-320-1235 (TTY: 711)** 번으로 문의하십시오.

ພາສາລາວ [Lao]: ມີບໍລິການພາສາ, ອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ຮູບແບບທາງເລືອກອື່ນບໍ່ເສຍຄ່າໃຫ້. ໂທ **877-320-1235 (TTY: 711)**.

Diné [Navajo]: Saad bee áná'álwo', bee haz'áanii, dóó naaltsoos t'áá ajiłii'ígíí bee ak'e'elyaaígíí t'áá jiik'eh hóló. **877-320-1235 (TTY: 711)** bich'į' hodíilnih.

नेपाली [Nepali]: नि:शुल्क भाषा सेवा, सहायक सामग्री र वैकल्पिक ढाँचाका सेवाहरू उपलब्ध छन् । **877-320-1235 (TTY: 711)** मा कल गर्नुहोस् ।

Polski [Polish]: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **877-320-1235 (TTY: 711)**.

Português [Brazilian Portuguese]: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **877-320-1235 (TTY: 711)**.

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫ਼ਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। **877-320-1235 (TTY: 711)** 'ਤੇ ਕਾਲ ਕਰੋ।

Русский [Russian]: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **877-320-1235 (TTY: 711)**.

Español [Spanish]: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al **877-320-1235 (TTY: 711)**.

Tagalog [Tagalog]: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **877-320-1235 (TTY: 711)**.

தமிழ் [Tamil]: மொழி,, உதவிப் பொருட்கள் மற்றும் மாற்று வடிவமைப்புச் சேவைகள் இலவசமாகக் கிடைக்கின்றன. **877-320-1235 (TTY: 711)** எண்ணை அழைக்கவும்.

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **877-320-1235 (TTY: 711)** కి కాల్ చేయండి.

اردو [Urdu]: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال **877-320-1235 (TTY: 711)**۔

Tiếng Việt [Vietnamese]: Có sẵn miễn phí các dịch vụ ngôn ngữ, hỗ trợ phụ trợ và định dạng thay thế. Hãy gọi **877-320-1235 (TTY: 711)**.

Òyìnbó [Yoruba]: Àwọn iṣẹ́ àtìlẹ́hìn ìrànlọ́wọ́ èdè, àti ọ̀nà kíkà míràn wà lárọ̀wọ́tó lọ́fẹ̀ẹ́.
Pe **877-320-1235 (TTY: 711)**.

This notice is available at **https://www.humana.com/legal/multi-language-support**.

Notes

Humana.

Humana Inc.
P.O. Box 14168
Lexington, KY 40512-4168

Important information about this plan

Humana.com

H4939_SB_MAPD_HMOPOS_002000_2027_M