2027

Summary of Benefits

HumanaChoice H7617-007 (PPO)

MO Rural

Select Counties in AR,MO,OK,WI

Our service area includes the following county/counties in Arkansas: Clay, Cross, Drew, Howard, Jackson, Lafayette, Polk, Sharp
Illinois: McHenry
Missouri: Adair, Andrew, Atchison, Caldwell, Chariton, Clark, Clinton, Daviess, DeKalb, Dunklin, Grundy, Henry, Holt, Johnson, Knox, Lewis, Linn, Macon, Marion, Mercer, Mississippi, Monroe, New Madrid, Pemiscot, Putnam, Ralls, Randolph, Ripley, Schuyler, Scotland, Shannon, Shelby, Sullivan, Worth
Oklahoma: Alfalfa, Atoka, Blaine, Choctaw, Cotton, Dewey, Grant, Greer, Haskell, Jackson, Jefferson, Kiowa, Latimer, Love, Major, Marshall, McCurtain, Nowata, Pushmataha, Tillman, Woods
Wisconsin: Adams, Buffalo, Burnett, Chippewa, Clark, Columbia, Crawford, Dane, Douglas, Dunn, Eau Claire, Florence, Green, Iowa, Iron, Jackson, Jefferson, Juneau, La Crosse, Lafayette, Langlade, Lincoln, Monroe, Oneida, Pepin, Pierce, Polk, Richland, Rock, Rusk, Sauk, Taylor, Trempealeau, Vernon, Vilas, Walworth.

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

- ☐ 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 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 providers outside of our network (non-contracted providers). However, while we will pay for 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.

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Let's talk about HumanaChoice H7617-007 (PPO)

Find out more about the HumanaChoice H7617-007 (PPO) plan – including the health and drug services it covers – in this easy-to-use booklet.

HumanaChoice H7617-007 (PPO) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, please refer to the plan's Evidence of Coverage on our website, **Humana.com/PlanInformation.**

To be eligible

To join HumanaChoice H7617-007 (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name

HumanaChoice H7617-007 (PPO)

How to reach us

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**

More about HumanaChoice H7617-007 (PPO)

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

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

As a member it's a good idea to select a doctor as your Primary Care Provider (PCP). HumanaChoice H7617-007 (PPO) has a network of doctors, hospitals, pharmacies and other providers.



A healthy partnership

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

Monthly Premium, Deductible and Limits

PLAN COSTS

Monthly plan premium	**$60** If you receive premium assistance, this plan premium may be reduced. You must keep paying your Medicare Part B premium.
Medical deductible *You pay the same amount as you would with Original Medicare.	**$292*** combined deductible The following services listed are excluded from the combined in-network and out-of-network deductible: In-Network only: Ambulance Services Chemotherapy Drugs and Administration Continuous Glucose Monitor Diabetic Monitoring Supplies Diagnostic Colonoscopy Diagnostic Mammography Durable Medical Equipment Other Medicare Part B Drugs Outpatient Blood Services Part A Services (Home Health, Inpatient, and Skilled Nursing) Both In-Network and Out-of-Network: Emergency Room Services Medicare Covered Preventive Services Medicare Part B Insulin Drugs Urgently Needed Services at Urgent Care Centers Services not covered by Original Medicare (i.e., Supplemental Benefits)
Pharmacy (Part D) deductible	**$0** deductible for Tier 1, Tier 2 and Tier 3 **$700** deductible for Tier 4 and Tier 5
Medical Maximum out-of-pocket responsibility	**$9,250** in-network **$13,900** combined in- and out-of-network The most you pay for copays, coinsurance and other costs for covered medical services for the year.

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****.*

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Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
INPATIENT HOSPITAL COVERAGE		
This plan covers an unlimited number of days for an inpatient stay.	**$362** copay per day for days 1-7 **$0** copay per day for days 8-90	**50%** of the cost
OUTPATIENT HOSPITAL COVERAGE		
Diagnostic colonoscopy	**$0** copay	**$0** copay
Diagnostic mammography	**$0** copay	**$0** copay
Surgery services	**$400** copay	**50%** of the cost
AMBULATORY SURGERY CENTER		
Diagnostic colonoscopy	**$0** copay	**$0** copay
Surgery services	**$300** copay	**50%** of the cost
DOCTOR VISITS		
Primary care provider (PCP)		
• PCP's office	**$0** copay	**35%** of the cost
• Telehealth	**$0** copay	**Not Covered**
Specialist		
• Specialist's office	**$50** copay	**35%** of the cost
• Telehealth	**$50** copay	**Not Covered**
PREVENTIVE CARE		
This plan covers all Medicare preventive services including: **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	**$0** copay	**$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.)

	IN-NETWORK	OUT-OF-NETWORK
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.		

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****.*

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Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
EMERGENCY CARE		
Emergency services at 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. When placed in observation, member pays observation cost-share instead of emergency room cost-share.	**$115** copay	**$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.	**$40** copay **$40** copay	**Not Covered** **$40** copay
WORLDWIDE COVERAGE		
• **Emergency ambulance** • **Emergency room - Hospital** • **Urgent care center** 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.		**$325** copay per date of service **$115** copay **$40** 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.)

	IN-NETWORK	OUT-OF-NETWORK
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Advanced imaging services (MRI, MRA, PET and CT scans)		
• Freestanding radiological facility	**$205** copay	**50%** of the cost
• Outpatient hospital	**$345** copay	**50%** of the cost
• PCP's office	**$330** copay	**50%** of the cost
• Specialist's office	**$330** copay	**50%** of the cost
Basic radiological services (X-rays)		
• Freestanding radiological facility	**$40** copay	**50%** of the cost
• Outpatient hospital	**$145** copay	**35%** of the cost
• PCP's office	**$0** copay	**35%** of the cost
• Specialist's office	**$50** copay	**35%** of the cost
• Urgent care center	**$40** copay	**$40** copay
Diagnostic mammography		
• Freestanding radiological facility	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
Diagnostic procedures and tests		
• Outpatient hospital	**$100** copay	**50%** of the cost
• PCP's office	**$0** copay	**35%** of the cost
• Specialist's office	**$50** copay	**35%** of the cost
• Urgent care center	**$40** copay	**$40** copay
Lab services		
• Freestanding laboratory	**$0** copay	**50%** of the cost
• Outpatient hospital	**$0** copay	**50%** of the cost
• PCP's office	**$0** copay	**50%** of the cost
• Specialist's office	**$0** copay	**50%** of the cost
• Urgent care center	**$0** copay	**$40** copay
Nuclear medicine and services		
• Freestanding radiological facility	**$250** copay	**50%** of the cost
• Outpatient hospital	**$250** copay	**50%** of the cost
Sleep study		
• Member's home	**$0** copay	**50%** of the cost
• Outpatient hospital	**$100** copay	**50%** of the cost
• Specialist's office	**$50** copay	**35%** 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****.*

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Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Therapeutic radiology (Radiation therapy)		
• Freestanding radiological facility	**20%** of the cost	**50%** of the cost
• Outpatient hospital	**20%** of the cost	**50%** of the cost
• Specialist's office	**$50** copay	**35%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**$50** copay	**35%** of the cost
Mandatory supplemental hearing benefit	**HER128** • **$0** copay for fitting, routine hearing exams up to 1 per year. • **$0** copay for follow-up provider visits up to 3 per year. • **$575** copay for each Level 1 prescription hearing aid up to 1 per ear per year. • **$750** 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.	**HER128** • **95%** of the cost for routine hearing exams up to 1 per year. • **95%** of the cost for fitting up to 1 per year. • **95%** of the cost for follow-up provider visits up to 3 per year. • **95%** of the cost for each prescription hearing aid up to 1 per ear per year. • Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. • To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. • Reimbursement will be limited to up to **5%** of the allowed amount on eligible items/services. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

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.)

	IN-NETWORK	OUT-OF-NETWORK
DENTAL SERVICES		
Medicare-covered dental	**$50** copay	**35%** of the cost
Mandatory supplemental dental benefit Limitations and exclusions may apply. Please see your Evidence of Coverage (EOC) for additional details. **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).	**DEN350** • **$0** copay for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **$0** copay for panoramic film or diagnostic x-rays up to 1 every 5 years. • **$0** copay for necessary nitrous oxide/analgesia with covered service up to 1 unit(s) per visit. • **$0** copay for bitewing x-rays up to 1 per year. • **$0** copay for emergency diagnostic exam, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **$0** copay for periodontal maintenance up to 4 per year.	**DEN350** • **$0** copay for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **$0** copay for panoramic film or diagnostic x-rays up to 1 every 5 years. • **$0** copay for necessary nitrous oxide/analgesia with covered service up to 1 unit(s) per visit. • **$0** copay for bitewing x-rays up to 1 per year. • **$0** copay for emergency diagnostic exam, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **$0** copay for periodontal maintenance up to 4 per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

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****.*

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Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
• 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). Visiting an in-network provider may result in significant savings. The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator for our nationwide network can be found at **Humana.com/FindCare**. **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.		

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.)

	IN-NETWORK	OUT-OF-NETWORK
Provider reimbursements • Network providers agree to bill us directly. 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) usual and customary fees 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** copay	**50%** of the cost
Medicare-covered diabetic eye exam	**$0** copay	**$0** copay
Medicare-covered vision services The provider locator for Medicare-covered vision can be found at **Humana.com/FindCare**.	**$50** copay	**35%** 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.	**VIS694** • **$0** copay for routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for routine exam. • **$50** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.	**VIS694** • **$0** copay for routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for routine exam. • **$50** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.

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****.*

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Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-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. Copayments, coinsurances, and deductibles paid for supplemental benefits do not count toward your maximum out-of-pocket amount.	• 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 will display the PLUS Provider indicator in the provider locator search results found at **Humana.com/FindCare**.	• Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. • Maximum benefit coverage amounts cannot be combined.
MENTAL HEALTH SERVICES		
Inpatient This plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$276** copay per day for days 1-7 **$0** copay per day for days 8-90	**50%** of the cost
Mental health therapy visits		
• Outpatient hospital	**$35** copay	**35%** of the cost
• Specialist's office	**$35** copay	**35%** of the cost
• Telehealth	**$35** copay	**Not Covered**
Outpatient substance abuse services		
• Outpatient hospital	**$35** copay	**35%** of the cost
• Specialist's office	**$35** copay	**35%** of the cost
• Telehealth	**$35** copay	**Not 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****.*

Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
SKILLED NURSING FACILITY (SNF)		
This plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$221** copay per day for days 21-100	**50%** of the cost for days 1-100
AMBULANCE		
Air	**20%** of the cost	**20%** of the cost
Ground	**$325** copay per date of service	**$325** copay per date of service
TRANSPORTATION		
	Not Covered	**Not Covered**
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	**50%** of the cost
• Specialist's office	**$0** copay	**50%** of the cost
Chemotherapy drugs		
• Outpatient hospital	**20%** of the cost	**50%** of the cost
• Specialist's office	**20%** of the cost	**50%** of the cost
Other Part B drugs		
• Outpatient hospital	**20%** of the cost	**50%** of the cost
• PCP's office	**20%** of the cost	**50%** of the cost
• Pharmacy	**20%** of the cost	**20%** of the cost
• Specialist's office	**20%** of the cost	**50%** of the cost
Part B Insulin		
• Outpatient hospital	**20%** of the cost	**50%** of the cost
• PCP's office	**20%** of the cost	**50%** of the cost
• Pharmacy	**20%** of the cost	**20%** of the cost
• Specialist's office	**20%** of the cost	**50%** 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.		

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****.*

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Prescription Drug Benefits

PLAN HIGHLIGHTS

$0 copays	**$0** copays at select pharmacy locations and tiers. Additional details below.
Deductible	**$0** deductible for Tier 1, Tier 2 and Tier 3
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.
100-day supply	Up to 100-day supply on eligible drugs
Excluded drug coverage	Additional drug coverage for the following: Erectile dysfunction (ED) drugs Prescription vitamins
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

DEDUCTIBLE

$0 deductible for Tier 1, Tier 2 and Tier 3. This plan has a **$700** deductible for Tier 4 and Tier 5 drugs. You pay the full cost of these drugs until you reach **$700**. Then, you only pay your cost-share, entering into the Initial Coverage Stage.

INITIAL COVERAGE

You pay the following until your total yearly out-of-pocket drug 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	$5	$15	$20	$60	$5	$0
Tier 3: Preferred Brand	17%	17%	17%	17%	17%	15%
Tier 4: Non-Preferred Drug	50%	50%	50%	50%	50%	50%
Tier 5: Specialty Tier	25%	N/A	25%	N/A	25%	N/A

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**.

Other pharmacies are available in our network. 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	16% up to $5	16% up to $15	16% up to $20	16% up to $60	16% up to $5	$0
Tier 3: Preferred Brand	17% up to $35	17% up to $105	17% up to $35	17% up to $105	17% up to $35	15% 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

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

Other pharmacies are available in our network. 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 and Excluded drugs.	
EXCLUDED DRUG COVERAGE	
Erectile dysfunction (ED) drugs	Select drugs covered at Tier 1 cost-share amount.
Prescription vitamins	Select drugs covered at Tier 1 cost-share amount.

*Refer to your Evidence of Coverage for more information on Excluded Drug coverage.

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.

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.

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
Acupuncture services (Medicare-covered)	**$50** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.	**$50** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Chiropractic services (Medicare-covered)	**$15** copay	**35%** of the cost
Podiatry services (Medicare-covered)	**$50** copay	**35%** of the cost
MEDICAL EQUIPMENT/SUPPLIES		
Continuous glucose monitor (CGM)		
• DME provider	**20%** of the cost	**50%** of the cost
• Pharmacy	**20%** of the cost	**50%** of the cost
• Preferred pharmacy	**$0** copay	**Not Covered**
Diabetic monitoring supplies		
• Diabetic supplier	**20%** of the cost	**50%** of the cost
• Network retail pharmacy	**10%** of the cost	**10%** of the cost
• Preferred diabetic supplier	**$0** copay	**Not Covered**
Durable medical equipment (DME)	**17%** of the cost	**50%** of the cost
Medical supplies at medical supplier	**17%** of the cost	**50%** of the cost
Prosthetics devices and related supplies at prosthetics provider	**17%** of the cost	**50%** of the cost
REHABILITATION SERVICES		
Cardiac rehabilitation services		
• Outpatient hospital	**$30** copay	**50%** of the cost
• Specialist's office	**$30** copay	**50%** of the cost
Occupational therapy		
• Comprehensive outpatient rehab facility	**$35** copay	**35%** of the cost
• Outpatient hospital	**$35** copay	**35%** of the cost
• Specialist's office	**$35** copay	**35%** 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****.*

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Additional Benefits (cont.)

Physical therapy		
• Comprehensive outpatient rehab facility	**$35** copay	**35%** of the cost
• Outpatient hospital	**$35** copay	**35%** of the cost
• Specialist's office	**$35** copay	**35%** of the cost
Pulmonary rehabilitation		
• Outpatient hospital	**$25** copay	**50%** of the cost
• Specialist's office	**$25** copay	**50%** of the cost
Speech therapy		
• Comprehensive outpatient rehab facility	**$35** copay	**35%** of the cost
• Outpatient hospital	**$35** copay	**35%** of the cost
• Specialist's office	**$35** copay	**35%** of the cost
Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD)		
• Outpatient hospital	**$20** copay	**50%** of the cost
• Specialist's office	**$20** copay	**50%** 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****.*

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**.

Travel Coverage

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

Humana Well Dine® Meal Program

$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).

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

Limited to 4 times per year.

Out-of-network: You are required to pay the full cost at the time of service when utilizing an out-of-network provider. Humana will reimburse you 5% of the allowed amount on eligible items/services.

To receive reimbursement from Humana for eligible items/services, the member must submit required documentation.

Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Rewards and Incentives - Go365® by Humana

Complete eligible healthy activities, like preventive screenings and exams, and get rewarded with Go365 Plus.

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.

Out-of-network: **95%** coinsurance for out-of-network fitness centers.

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Member is required to pay the full cost at the time of service when utilizing an out-of-network fitness center.

To receive reimbursement from Humana for eligible items/services, the member must submit required documentation.

Reimbursement will be limited to up to **5%** of the allowed amount on eligible items/services.

Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Optional Supplemental Benefits

Customize your coverage for an extra monthly premium. You can enroll in the following to help create your Medicare plan.

$61.80
Monthly premium

MyOption DEN972
MyOption DEN972 is an Optional Supplemental Benefit (OSB) package that can be purchased for an additional monthly premium to replace any Mandatory Supplemental Dental Benefits that are offered within your Medicare Advantage plan. If purchased, the OSB will entirely replace the Mandatory Supplemental dental coverage defined in your benefits package. This means you should disregard any language in the Mandatory Supplemental Dental Benefit section contained in Chapter 4 of the Evidence of Coverage (EOC). When you enroll, you will receive a new ID card showing your new DEN972 listed on the back. Any claim paid under the current year Mandatory Supplemental Benefit will apply toward the annual OSB maximum plan benefit.

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 within the first 3 months of enrollment in your Medicare Advantage plan by contacting your agent or calling OSB sales at 888-413-7026. 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.

MyOption (DEN972) The MyOption Dental benefit helps make it easy for you to plan for your dental care. This benefit has no deductible. For detailed information on this OSB, please see the EOC.

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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.

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.

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

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.

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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**.

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Notice of Availability - Auxiliary Aids and Services Notice

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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)**.

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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**.

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

Important information about this plan

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