2016

Summary of Benefits
Optional Supplemental Benefits

HumanaChoice®
H6609-012 (PPO)

Intermountain
Select Counties in ID, OR, WA and UT

Humana®

2016

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SECTION 1

Summary of Benefits
January 1, 2016 - December 31, 2016

This booklet gives you 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. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **HumanaChoice H6609-012 (PPO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **HumanaChoice H6609-012 (PPO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your 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, 7 days a week. TTY users should call **1-877-486-2048**.

Sections in this booklet

- Things to Know About **HumanaChoice H6609-012 (PPO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Optional Benefits (you must pay an extra premium for these benefits)

This document is available in other formats such as Braille and large print.
This document may be available in a non-English language. For additional information, call us at 1-800-457-4708.
Es posible que este documento esté disponible en otros idiomas aparte de inglés. Para obtener información adicional, llame al Servicio al Cliente al número de teléfono que se indica a continuación.

Things to Know About HumanaChoice H6609-012 (PPO)

Hours of Operation

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Local time.
- From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Local time.

HumanaChoice H6609-012 (PPO) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-800-457-4708 .
- If you are not a member of this plan, call toll-free 1-800-833-2364 .
- Our website: **http://www.humana-medicare.com**

Who can join?

To join **HumanaChoice H6609-012 (PPO)** , you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.
Our service area includes the following counties in
Idaho: Ada, Bannock, Boise, Bonneville, Canyon, Gem, Kootenai, and Payette;
Oregon: Benton, Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lincoln, Linn, Malheur, Multnomah, Polk, and Washington;
Utah: Daggett, Davis, Salt Lake, Uintah, Utah, and Weber;
and Washington: Clark, Cowlitz, Island, King, Kitsap, Kittitas, Snohomish, Spokane, and Walla Walla.

Which doctors and hospitals can I use?

HumanaChoice H6609-012 (PPO) has a network of doctors, hospitals, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.
You can see our plan's provider directory at our website (www.humana.com/members/tools).
Or, call us and we will send you a copy of the provider directory.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and more.

- **Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get more than what is covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

HumanaChoice H6609-012 (PPO) covers Part B drugs including chemotherapy and some drugs administered by your provider. However, this plan does not cover Part D prescription drugs.

Summary of Benefits
January 1, 2016 - December 31, 2016

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services	
How much is the monthly premium?	**$0** per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • **$3,600** for services you receive from in-network providers. • **$4,500** for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain benefits from any provider. Contact us for services that apply.

Humana is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

Covered Medical and Hospital Benefits

Note:
- Services with a [1] may require prior authorization.
- Services with a [2] may require a referral from your doctor.

OUTPATIENT CARE AND SERVICES	
Acupuncture	Not covered
Ambulance[1]	• In-network: **$300** copay • Out-of-network: **$300** copay
Chiropractic Care[1]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: **$20** copay • Out-of-network: **50%** of the cost
Dental Services[1]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: **$25** copay • Out-of-network: **50%** of the cost

Diabetes Supplies and Services[1]	Diabetes monitoring supplies: • In-network: **0–20%** of the cost, depending on the supply • Out-of-network: **50%** of the cost Diabetes self-management training: • In-network: **You pay nothing** • Out-of-network: **50%** of the cost Therapeutic shoes or inserts: • In-network: **You pay nothing** • Out-of-network: **50%** of the cost
Diagnostic Tests, Lab and Radiology Services, and X-Rays *(Costs for these services may be different if received in an outpatient surgery setting)*[1]	Diagnostic radiology services (such as MRIs, CT scans): • In-network: **$25–225** copay or **25%** of the cost, depending on the service • Out-of-network: **50%** of the cost Diagnostic tests and procedures: • In-network: **$0–50** copay or **25%** of the cost, depending on the service • Out-of-network: **50%** of the cost Lab services: • In-network: **$0–25** copay or **25%** of the cost, depending on the service • Out-of-network: **50%** of the cost Outpatient x-rays: • In-network: **$10–50** copay or **25%** of the cost, depending on the service • Out-of-network: **50%** of the cost Therapeutic radiology services (such as radiation treatment for cancer): • In-network: **20%** of the cost • Out-of-network: **50%** of the cost The copay depends on where the service is provided. Please call Customer Care for further details.
Doctor's Office Visits	Primary care physician visit: • In-network: **$10** copay • Out-of-network: **50%** of the cost Specialist visit: • In-network: **$25** copay • Out-of-network: **50%** of the cost

Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	• In-network: **20%** of the cost • Out-of-network: **30%** of the cost If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.
Emergency Care	**$75** copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.
Foot Care *(podiatry services)*[1]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: **$25** copay • Out-of-network: **50%** of the cost
Hearing Services[1]	Exam to diagnose and treat hearing and balance issues: • In-network: **$25** copay • Out-of-network: **50%** of the cost
Home Health Care[1]	• In-network: **You pay nothing** • Out-of-network: **50%** of the cost

Mental Health Care[1]	Inpatient visit:
	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.
	
	Our plan covers 90 days for an inpatient hospital stay.
	
	Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.
	
	• In-network:
	  • **$275** copay per day for days 1 through 5
	  • **You pay nothing** per day for days 6 through 90
	• Out-of-network:
	  • **50%** of the cost per stay
	
	Outpatient group therapy visit:
	• In-network: **$25** copay
	• Out-of-network: **50%** of the cost
	
	Outpatient individual therapy visit:
	• In-network: **$25** copay
	• Out-of-network: **50%** of the cost
	
	You pay this amount each time you are admitted or transferred to a facility.

Outpatient Rehabilitation[1]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: **$10** copay or **20%** of the cost, depending on the service • Out-of-network: **50%** of the cost Occupational therapy visit: • In-network: **$25** copay or **20%** of the cost, depending on the service • Out-of-network: **50%** of the cost Physical therapy and speech and language therapy visit: • In-network: **$25** copay or **20%** of the cost, depending on the service • Out-of-network: **50%** of the cost • In-Network • Cardiac Therapy Rehabilitation – Specialist: **$10** copayment – Outpatient: **20%** coinsurance • Occupational, Physical, Speech Therapy – Specialist: **$25** copayment – Outpatient: **20%** coinsurance – Comprehensive Outpatient Rehab: **$25** copayment
Outpatient Substance Abuse[1]	Group therapy visit: • In-network: **$25-55** copay or **25%** of the cost, depending on the service • Out-of-network: **50%** of the cost Individual therapy visit: • In-network: **$25-55** copay or **25%** of the cost, depending on the service • Out-of-network: **50%** of the cost • In-Network: • **25%** coinsurance Outpatient hospital • **$55** copayment Partial hospitalization • **$25** copayment Specialist's Office • Out-of-Network: • **50%** coinsurance Outpatient hospital • **50%** coinsurance Partial hospitalization • **50%** coinsurance Specialist's Office

Outpatient Surgery[1]	Ambulatory surgical center: • In-network: **20%** of the cost • Out-of-network: **50%** of the cost Outpatient hospital: • In-network: **25%** of the cost • Out-of-network: **50%** of the cost
Over-the-Counter Items	Please visit our website to see our list of covered over-the-counter items. – You are eligible to receive a **$15** monthly benefit toward the purchase of selected over-the-counter items when you use Humana's mail order service. – For more information or to request an order form, please call Customer Care.
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: • In-network: **20%** of the cost • Out-of-network: **50%** of the cost Related medical supplies: • In-network: **20%** of the cost • Out-of-network: **50%** of the cost
Renal Dialysis[1]	• In-network: **20%** of the cost • Out-of-network: **20%** of the cost
Transportation	Not covered

Urgently Needed Services	**$10-25** copay or **50%** of the cost (up to **$65**), depending on the service
	• In-network:
	  • **$10** copayment Primary care
	  • **$25** copayment Specialist's office
	  • **$25** copayment urgent care center
	• Out-of-Network:
	  • **50%** coinsurance Primary care
	  • **50%** coinsurance Specialist's office
	  • **50%** coinsurance urgent care center

Vision Services[1]	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: **$0-25** copay, depending on the service • Out-of-network: **50%** of the cost Routine eye exam (for up to 1 every year): • In-network: **$0** copay • Out-of-network: **$0** copay Our plan pays up to **$40** every year for routine eye exams from any provider. Eyeglasses or contact lenses after cataract surgery: • In-network: **You pay nothing** • Out-of-network: **You pay nothing**
Preventive Care	• In-network: **You pay nothing** • Out-of-network: **0-50%** of the cost, depending on the service Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
Hospice	**You pay nothing** for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.

INPATIENT CARE	

Inpatient Hospital Care[1]	Our plan covers an unlimited number of days for an inpatient hospital stay.
	
	• In-network:
	  • **$275** copay per day for days 1 through 5
	  • **You pay nothing** per day for days 6 through 60
	  • **$100** copay per day for days 61 through 90
	  • **You pay nothing** per day for days 91 and beyond
	• Out-of-network:
	  • **50%** of the cost per stay
	
	You pay this amount each time you are admitted or transferred to a facility.

Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet

Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF.
	• In-network:
	  • **You pay nothing** per day for days 1 through 20
	  • **$160** copay per day for days 21 through 100
	• Out-of-network:
	  • **50%** of the cost per stay

Prescription Drug Benefits	
How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: • In-network: **20%** of the cost • Out-of-network: **50%** of the cost Other Part B drugs[1]: • In-network: **20%** of the cost • Out-of-network: **50%** of the cost Our plan does not cover Part D prescription drug.
Optional Benefits *(you must pay an extra premium each month for these benefits)*	
Package 1: MyOption Vision	Benefits include: • Eye Exams • Eyewear
How much is the monthly premium?	Additional **$15.30** per month. You must keep paying your Medicare Part B premium and your **$0** monthly plan premium.
How much is the deductible?	This package does not have a deductible.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit for certain benefits.

Package 2: MyOption Plus	Benefits include: • Preventive Dental • Comprehensive Dental • Eye Exams • Eyewear
How much is the monthly premium?	Additional **$32.00** per month. You must keep paying your Medicare Part B premium and your **$0** monthly plan premium.
How much is the deductible?	**$50** per year.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit for certain benefits.
Package 3: MyOption Platinum Dental	Benefits include: • Preventive Dental • Comprehensive Dental
How much is the monthly premium?	Additional **$42.50** per month. You must keep paying your Medicare Part B premium and your **$0** monthly plan premium.
How much is the deductible?	This package does not have a deductible.
Is there a limit on how much the plan will pay?	Our plan pays up to **$2,000** every year. Our plan has additional coverage limits for certain benefits. For more information on customizing your Humana Medicare Advantage coverage, for an additional monthly premium, please see the 2016 Optional Supplemental Benefits book. Ask your agent or call us if you need help finding this information.

Additional Information About HumanaChoice H6609-012 (PPO)

As a member you have to choose an in-network provider, listed in your plan directory, as your Primary Care Physician (PCP). A PCP can focus on your total health to help ensure you get preventive care, provide timely access to services and coordinate with other doctors; however, a referral to see another doctor is not needed.

Additional Supplemental Benefits covered by the plan:
Incentive Programs - Rewards members for completing preventive screenings and activities
SilverSneakers® Fitness Program - Basic fitness center membership including fitness classes
Well Dine Meal Program - Humana's meal program for members following an inpatient stay in the hospital or nursing facility
Member Assistance Program - A program that includes telephonic counseling sessions and online resources to help cope with life changes and consultations for adult care and child care issues
HumanaFirst® - A 24 Hour Nurse Advice Hotline
Smoking Cessation Program - A program may include web based or telephonic counseling/coaching and Nicotine Replacement Therapy

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2016

Optional Supplemental Benefits

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Humana®

My Options, My Choice
Adding Benefits to Your Plan

You're unique and have unique needs for staying healthy. That's why Humana offers optional supplemental benefits (OSB). For an extra premium, each of these extra benefit choices lets you customize your Humana Medicare Advantage plan.

These benefits make it easier for you to get more coverage when you need it. They can also help you control your costs.

You can add these extra benefits when you sign up for your Medicare Advantage plan or any time during the year.

You have many choices. The information in this booklet will tell you about the benefits you can add to your plan. If you have questions, you can call us at 1-888-866-3154 (TTY: 711). We are available seven days a week, from 8 a.m. - 8 p.m. local time. However, please note that our automated phone system may answer your call during weekends and holidays from February 15 - September 30. Please leave your name and telephone number, and we will call you back by the end of the next business day.

MyOption℠ Vision

The MyOption℠ Vision benefit helps you plan for your vision care. It includes a yearly exam, as well as **$375** to use for one set of eyeglass frames and one pair of lenses, **and/or** contact lenses (conventional or disposable).

There's no deductible and no waiting period before your coverage begins. The monthly premium for this OSB is **$15.30**. Here's how the benefit works:

Covered vision benefits	**EyeMed network vision provider***	**Non-EyeMed network vision provider****
Routine exam with refraction/dilation as necessary	**$40 allowance*****	**$40 allowance**
One set of eyeglass frames and one pair of lenses, **and/or** contact lenses (conventional or disposable) Eyeglass lens treatments to include UV and scratch resistance	**$375** benefit (combined in and out of network)	**$375** reimbursement (combined in and out of network)
Frequency:		
Routine exam	Once every 12 months	

Covered vision benefits	EyeMed network vision provider*	Non-EyeMed network vision provider**
Frequency:		
One set of eyeglass frames and one pair of lenses, **and/or** contact lenses (conventional or disposable)	Once every 12 months	

Covered vision services are subject to conditions, limitations, exclusions, and maximums. Please see your Evidence of Coverage for details.

*Network providers have agreed to provide services at an in-network rate. If you see a network provider, you can't be billed more than the in-network rate.

**Non-network providers haven't agreed to provide services at an in-network rate. Humana negotiates rates for vision services. When you see a non-network provider, you'll pay your part of the negotiated rate (your coinsurance). If your provider charges more than that rate, you may have to pay more.

***Visit any in-network EyeMed Select vision provider, and your routine exam charge will not exceed the $40 allowance.

MyOption℠ Plus

MyOption℠ Plus makes it easy to plan for both your dental and vision care. For dental care, this plan has a **$50** deductible and covers the full cost for two routine dental exams per year with an in-network provider. For vision care, this benefit has no deductible. You also get a **$290** allowance per year to use for either:

- One set of eyeglass frames and one pair of lenses
- **Or** contact lenses (includes conventional or disposable)

There's a maximum annual benefit of **$1,000**, and there's no waiting period before your coverage begins. The premium for this OSB is **$32.00**. Here's how the benefit works:

Covered dental services	You pay in network*	You pay out of network**	Optional supplemental benefits
Preventive and diagnostic dental services			All benefit limitations run on a calendar year
Oral examinations	**0%**	**30%**	Two per year
Dental prophylaxis (cleanings)	**0%**	**30%**	Two per year
Bitewing X-ray	**0%**	**30%**	One per year
Basic dental services (minor restorative)			
Amalgam restorations (fillings)	**50%**	**55%**	Two per year
Composite resin restorations (fillings)***	**50%**	**55%**	
Extractions	**50%**	**55%**	Two per year

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered dental services	You pay in network*	You pay out of network**	Optional supplemental benefits
Basic dental services (minor restorative)			
Crown or bridge re-cement	**50%**	**55%**	One per year
Emergency treatment for pain	**50%**	**55%**	Two per year
Covered vision benefits	**EyeMed network vision provider***	**Non-EyeMed network vision provider****	**All benefit limitations run on a calendar year**
Routine exam with refraction/dilation as necessary	**$40 allowance********	**$40 allowance**	One every 12 months
One set of eyeglass frames and one pair of lenses	**$290** benefit (combined in and out of network)	**$290** reimbursement (combined in and out of network)	One every 12 months
Contact lenses (instead of eyeglass frames; includes conventional or disposable)	**$290** benefit (combined in and out of network)	**$290** reimbursement (combined in and out of network)	One every 12 months

Covered dental and vision services are subject to conditions, limitations, exclusions, and maximums. Please see your Evidence of Coverage for details.

*Network providers have agreed to provide services at an in-network rate. If you see a network provider, you can't be billed more than the in-network rate.

**Non-network providers haven't agreed to provide services at an in-network rate. Humana negotiates rates for dental and vision services. When you see a non-network provider, you'll pay your part of the negotiated rate (your coinsurance). If your provider charges more than that rate, you may have to pay more.

***Composite resin restorations (fillings) benefit as follows:
- Anterior (front) teeth: Composite restoration benefit as previously displayed
- Posterior (back) teeth: The benefit for a composite restoration will be based on the cost of an amalgam restoration. Member is responsible for the remaining cost difference between a composite restoration and an amalgam restoration.

****Visit any in-network EyeMed Select vision provider, and your routine exam charge will not exceed the $40 allowance.

MyOption℠ Platinum Dental

The MyOption℠ Platinum Dental benefit helps you plan for your dental care. This benefit has no deductible and pays the full cost for two routine exams per year with an in-network provider.

The benefit pays some of the cost for basic procedures like fillings, extractions (pulling teeth), and preventive oral cancer screenings. It also includes coverage for major services like crowns and periodontal maintenance after periodontal therapy. There's a maximum annual benefit of **$2,000**. There's no waiting period before your coverage begins. The premium for this OSB is **$42.50**. Here's how the benefit works:

Covered dental services	You pay in network*	You pay out of network**	Optional supplemental benefits
Preventive and diagnostic dental services			All benefit limitations run on a calendar year
Oral examinations	**0%**	**50%**	Two per year
Cancer screening	**0%**	**50%**	One per year
Emergency exam	**0%**	**50%**	Two per year
Dental prophylaxis (cleanings)	**0%**	**50%**	Two per year
Bitewing X-ray	**0%**	**50%**	One per year
Basic dental services (minor restorative)			
Amalgam restorations (fillings) and composite resin restorations (fillings)	**0%**	**50%**	Two per year
Extractions, nonsurgical and surgical	**50%**	**55%**	Two per year
Crown or bridge re-cement	**50%**	**55%**	One per year
Emergency treatment for pain	**50%**	**55%**	Two per year
Major dental services (endodontics, periodontics, and oral surgery)			
Root canal treatment	**70%**	**75%**	One per year
Crowns	**70%**	**75%**	One per year
Periodontal scaling and root planing (deep cleaning)	**70%**	**75%**	One procedure per quadrant every three years
Periodontal maintenance	**70%**	**75%**	Two per year
Denture adjustments (not covered within six months of initial placement)	**70%**	**75%**	One per year
Complete dentures (including routine post-delivery care)	**70%**	**75%**	One upper and/or one lower complete denture every five years
Partial dentures	**70%**	**75%**	One upper and/or one lower partial denture every five years

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered dental services	You pay in network*	You pay out of network**	Optional supplemental benefits
Major dental services (endodontics, periodontics, and oral surgery)			
Denture reline (not allowed on spare dentures)	**70%**	**75%**	One per year
Restoration implant services	**70%**	**75%**	One per year

Covered dental services are subject to conditions, limitations, exclusions, and maximums. Please see your Evidence of Coverage for details.

*Network dentists have agreed to provide services at an in-network rate. If you see a network dentist, you can't be billed more than the in-network rate.

**Non-network dentists haven't agreed to provide services at an in-network rate. Humana negotiates rates for dental services. When you see a non-network dentist, you'll pay your part of the negotiated rate (your coinsurance). If your dentist charges more than that rate, you may have to pay more.

Humana is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal. Humana MyOption Optional Supplemental Benefits (OSB) are only available to members of certain Humana Medicare Advantage (MA) plans. Members of Humana plans that offer OSBs may enroll in OSBs throughout the year. Benefits may change on January 1st each year. Enrollees must continue to pay the Medicare Part B premium, their Humana premium, and the OSB premium.

This information is available for free in other languages. Please contact a licensed Humana sales agent at 1-800-833-2364, Monday - Sunday 8 a.m. - 8 p.m. TTY users, please call 711.

Esta información está disponible gratuitamente en otros idiomas. Póngase en contacto con un agente de ventas certificado de Humana al 1-800-833-2364, de lunes a domingo, de 8 a. m. a 8 p. m. Los usuarios de TTY deben llamar al 711.

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Notes

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-457-4708. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-457-4708. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-457-4708。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-457-4708。我們講中文的人員將樂意為您提供幫助。 這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-457-4708. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-457-4708. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-457-4708. sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-457-4708. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-457-4708 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-457-4708. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات الترجمة الفورية المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الإتصال بنا على.1-800-457-4708. سيقوم شخص ما يتحدث اللغة العربية بمساعدتك. هذه الخدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-457-4708 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-457-4708. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-457-4708. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-457-4708. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-457-4708. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-457-4708にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

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