

2023

Summary of Benefits

Humana Group Medicare Advantage HMO Plan
HMO 076/251

ELA - Basic Deluxe



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Humana[®]

Our service area includes all municipalities in Puerto Rico.

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Let's talk about the **Humana Group Medicare Advantage HMO Plan.**

Find out more about the Humana Group Medicare Advantage HMO plan – including the services it covers – in this easy-to-use guide.

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, refer to the "Evidence of Coverage".

To be eligible

To join the Humana Group Medicare Advantage HMO plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Humana Group Medicare Advantage HMO plan has a network of doctors, hospitals, and other providers. For more information, please call Group Medicare Customer Care.

Plan name:

Humana Group Medicare Advantage HMO plan

How to reach us:

Members should call toll-free **1-866-773-5959** for questions (TTY/TDD 711)

Call Monday – Friday, 8 a.m. - 9 p.m. Eastern Time.

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



A healthy partnership

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



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Monthly Premium, Deductible and Limits

IN-NETWORK

PLAN COSTS

Monthly premium

You must keep paying your Medicare Part B premium.

For information concerning the actual premiums you will pay, please contact Humana, your employer/union group, or your employer group benefits plan administrator.

Part B premium reduction

Your plan will reduce your Monthly Part B premium by up to **\$170.10**.

Medical deductible

This plan does not have a deductible.

Maximum out-of-pocket responsibility

The most you pay for copays, coinsurance and other costs for medical services for the year.

In-Network Maximum Out-of-Pocket

\$6,700 out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; Fitness Program; Health Education Services; Meal Benefit; Smoking Cessation (Additional) and the Plan Premium.

If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.



Covered Medical and Hospital Benefits

IN-NETWORK

ACUTE INPATIENT HOSPITAL CARE

Our plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

\$50 per admit

OUTPATIENT HOSPITAL COVERAGE

Outpatient hospital visits

\$0 to **\$25** copay or **5%** to **20%** of the cost

Ambulatory surgical center

\$25 copay

DOCTOR OFFICE VISITS

Primary care provider (PCP)

\$0 copay

Specialists

\$5 copay

PREVENTIVE CARE

Including: Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Any additional preventive services approved by Medicare during the contract year will be covered.

Covered at no cost

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Note: A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization and referrals from providers.



Covered Medical and Hospital Benefits

IN-NETWORK

EMERGENCY CARE

Emergency room**\$50** copay for Medicare-covered emergency room visit(s)

If you are admitted to the hospital within 24 hours for the same condition, 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.

Urgently needed services**\$0 to \$5** copay

Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.

DIAGNOSTIC SERVICES, LABS AND IMAGING

Diagnostic radiology**10%** of the cost

\$65 Maximum Out-of-Pocket per visit for Medicare-covered diagnostic radiology services

Lab services**5%** of the cost**Diagnostic tests and procedures****\$0 to \$7** copay or **20%** of the cost**Outpatient X-rays****\$0** copay**Radiation therapy****\$7** copay

HEARING SERVICES

Medicare-covered hearing**\$7** copay**Routine hearing****\$0** copay for fitting/evaluation, routine hearing exams up to 1 per year. **\$750** maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year.

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Note: A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization and referrals from providers.



Covered Medical and Hospital Benefits

IN-NETWORK

DENTAL SERVICES

Medicare-covered dental	\$7 copay (services include surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease)
Routine dental	<p>0% of the cost for bitewing x-rays up to 1 set(s) every 2 years.</p> <p>0% of the cost for amalgam and/or composite filling up to 1 per tooth every 3 years.</p> <p>0% of the cost for comprehensive oral exam, panoramic film up to 1 every 3 years.</p> <p>0% of the cost for crown up to 1 per tooth every 5 years.</p> <p>0% of the cost for bridges, complete dentures, partial dentures up to 1 every 5 years.</p> <p>0% of the cost for other restorative services - core buildup and prefabricated post and core up to 1 per tooth per lifetime.</p> <p>0% of the cost for scaling and root planing (deep cleaning) up to 1 per quadrant per year.</p> <p>0% of the cost for periodontal debridement up to 1 per year.</p> <p>0% of the cost for periodic oral exam, prophylaxis (cleaning) up to 2 per year.</p> <p>0% of the cost for intraoral x-rays up to 6 per year.</p> <p>0% of the cost for adjustments to dentures, extractions, root canal up to unlimited per year.</p> <p>0% of the cost for implant services up to 1 per tooth per lifetime.</p> <p>0% of the cost for implant supported prosthetics up to 1 per tooth every 5 years.</p> <p>\$3,000 maximum benefit coverage amount per year for adjustments to dentures, complete dentures, crown, partial dentures, other restorative services - core buildup and prefabricated post and core, bridges, implant services, and implant supported prosthetics.</p>

VISION SERVICES

Medicare-covered vision services	\$7 copay (services include diagnosis and treatment of diseases and injuries of the eye)
Medicare-covered diabetic eye exam	\$0 copay
Medicare-covered glaucoma screening	\$0 copay

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Covered Medical and Hospital Benefits

IN-NETWORK

Medicare-covered eyewear (post-cataract)

\$0 copay

Routine vision

\$0 copay for routine exam (includes refraction) up to 1 per year.
\$500 maximum benefit coverage amount per year for contact lenses, eyeglasses (lenses and frames), including lens options such as ultraviolet protection and scratch resistant coating, fitting for eyeglasses (lenses and frames).

MENTAL HEALTH SERVICES

Inpatient

\$50 per admit

The inpatient hospital care limit applies to inpatient mental services provided in a general hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. 190 day lifetime limit in a psychiatric facility

Outpatient group and individual therapy visits

Outpatient therapy visit:
\$0 to **\$7** copay
Partial Hospitalization:
\$0 copay

SKILLED NURSING FACILITY

Our plan covers up to 100 days in a SNF.

\$0 copay per day for days 1-100

No 3-day hospital stay is required.

Plan pays \$0 after 100 days

PHYSICAL THERAPY

\$7 copay

AMBULANCE

Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.

\$0 copay



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Covered Medical and Hospital Benefits

IN-NETWORK

TRANSPORTATION

\$0 copay for plan approved location up to 24 one-way trip(s) per year by car, van, wheelchair access vehicle.

PART B PRESCRIPTION DRUGS

\$0 copay or **0%** of the cost

ACUPUNCTURE SERVICES

Medicare-covered acupuncture visit(s) for chronic low back pain **\$5** copay

20 visit limit per plan year

Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements.

Routine acupuncture **\$15** copay
6 visit limit per plan year

ALLERGY

Allergy shots & serum **\$0 to \$7** copay

CHIROPRACTIC SERVICES

Medicare-covered chiropractic visit(s) **\$5** copay

Routine chiropractic visit(s) **\$7** copay
15 visit limit per plan year

COVID-19

Testing and Treatment Plan specific cost share is applicable to hospitalization, medical services, and FDA approved Rx with confirmed COVID-19 diagnosis.

DIABETES MANAGEMENT TRAINING

\$0 copay

FOOT CARE (PODIATRY)

Medicare-covered foot care **\$5** copay

HOME HEALTH CARE

\$0 copay





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Covered Medical and Hospital Benefits

IN-NETWORK

MEDICAL EQUIPMENT/SUPPLIES

Durable medical equipment (like wheelchairs or oxygen)	0% to 10% of the cost
Medical supplies	0% of the cost
Prosthetics (artificial limbs or braces)	20% of the cost
Diabetes monitoring supplies	\$0 copay or 10% of the cost

OUTPATIENT SUBSTANCE ABUSE

Outpatient group and individual substance abuse treatment visits	\$0 to \$7 copay
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OVER-THE-COUNTER ITEMS

\$25 maximum benefit coverage amount per month for over-the-counter (OTC) prepaid card to purchase eligible OTC health and wellness products at participating retailers. Unused funds carry over to the next month and expire at the end of the plan year.

REHABILITATION SERVICES

Occupational and speech therapy	\$7 copay
Cardiac rehabilitation	\$7 copay
Pulmonary rehabilitation	\$7 copay

RENAL DIALYSIS

Renal dialysis	\$0 copay
Kidney disease education services	\$0 copay

TELEHEALTH SERVICES (in addition to Original Medicare)

Primary care provider (PCP)	\$0 copay
Specialist	\$5 copay
Urgent care services	\$0 copay
Substance abuse or behavioral health services	\$0 copay

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Covered Medical and Hospital Benefits

IN-NETWORK

FITNESS AND WELLNESS

SilverSneakers® is a total health and physical activity program that provides access to exercise equipment, group fitness classes, and social events.

HEALTH EDUCATION SERVICES

Personal Health Coaching is an interactive inbound and outreach on-line and telephonic wellness coaching for Medicare participants who elect to participate, for wellness improvement, including weight management, nutrition, exercise, back care, blood pressure management, and blood sugar management.

MEAL BENEFIT

After a member's overnight inpatient stay in a hospital or skilled nursing facility, members are eligible for nutritious meals delivered to their door at no cost.

SMOKING CESSATION (ADDITIONAL)

A comprehensive smoking cessation program available online, email and phone. Personal coaches assist via establishing goals and providing articles and resources to aid in the effort to quit smoking.

HOSPICE

You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.

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Notes



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Important

At Humana, it is important you are treated fairly.

Humana and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable federal civil rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
If you need help filing a grievance, call **1-866-773-5959** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

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Multi-Language Insert

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 1-866-773-5959 (TTY: 711). Someone who speaks English 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 1-866-773-5959 (TTY: 711). 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 1-866-773-5959 (TTY: 711)。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 1-866-773-5959 (TTY: 711)。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 1-866-773-5959 (TTY: 711). 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 1-866-773-5959 (TTY: 711). 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 quý vị cần thông dịch viên xin gọi 1-866-773-5959 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-773-5959 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-773-5959 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

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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 1-866-773-5959 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY: 711) 1-866-773-5959. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة 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 1-866-773-5959 (TTY: 711) 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 1-866-773-5959 (TTY: 711). 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 1-866-773-5959 (TTY: 711). 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 1-866-773-5959 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

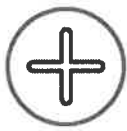
Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-773-5959 (TTY: 711). Ta usługa jest bezpłatna.

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。通訳をご用命になるには、1-866-773-5959 (TTY: 711) にお電話ください。日本語を話す人が支援いたします。これは無料のサービスです。

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Find out **more**



You can see your plan's provider directory at **Humana.com** or call us at the number listed at the beginning of this booklet and we will send you one.

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

If you want to compare our plan with other Medicare health plans, you can call your employer or union sponsoring this plan to find out if you have other options through them.

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.

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SB076251EN23

2023

Prescription Drug Summary of Benefits

Humana Group Medicare Advantage Plan
Rx 170

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Let's talk about the **Humana Group Medicare Advantage Rx Plan.**

Find out more about the Humana Group Medicare Advantage Rx plan – including the services it covers – in this easy-to-use guide.

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, refer to the "Evidence of Coverage".

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Deductible

Pharmacy (Part D) deductible

This plan does not have a deductible.



Prescription Drug Benefits

Initial coverage (after you pay your deductible, if applicable)

You pay the following until your total yearly drug costs reach **\$4,660**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

Tier	Standard Retail Pharmacy	Standard Mail Order
30-day supply		
1 (Preferred Generic)	\$0 copay	\$0 copay
2 (Preferred Brand)	\$0 copay	\$0 copay
3 (Non-Preferred Drug)	\$10 copay	\$10 copay
4 (Specialty Tier)	25% of the cost	25% of the cost
90-day supply		
1 (Preferred Generic)	\$0 copay	\$0 copay
2 (Preferred Brand)	\$0 copay	\$0 copay
3 (Non-Preferred Drug)	\$30 copay	\$20 copay
4 (Specialty Tier)	N/A	N/A

Some Insulin are covered at **100% for all members.

There may be generic and brand-name drugs, as well as Medicare-covered drugs, in each of the tiers. To identify commonly prescribed drugs in each tier, see the Prescription Drug Guide/Formulary. To view the most complete and current Drug Guide information online, visit www.humana.com/SearchResources, locate Prescription Drug section, select www.humana.com/MedicareDrugList link; under Printable drug lists, click Printable Drug lists, select future plan year, select Group Medicare under Plan Type and search for GRP29.

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ADDITIONAL DRUG COVERAGE

Home Infusion Therapy Drugs

If you take certain types of infusion drugs covered under our Medicare Advantage Prescription Drug plans (MA/PD), you may qualify for this service, which helps you and your doctor manage your care without ongoing hospitalization. In some situations home infusion drugs will be covered based on the tier of the drug at the same cost share amount as listed in the chart above when you have reached a total yearly drug cost of **\$4,660**. This service includes coverage for the "Coverage Gap" portion of your plan. Drugs included in this coverage are those that would be used as an alternative to inpatient treatment. Your cost for the medication may be the same as it is before the coverage gap sets in. Your out-of-pocket expenses while using this service apply to your "true out-of-pocket" maximum, which is **\$7,400** for 2023.

Original Medicare excluded drugs

Certain drugs excluded by Original Medicare are covered under this plan. You pay the cost share associated with the tier level for certain Erectile Dysfunction drugs. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage stage.

Contact Humana Group Medicare Customer Care at the phone number on the back of your membership card for more details.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **\$4,660**. After you enter the coverage gap, you pay a portion of the plan's cost for covered brand name drugs and covered generic drugs until your costs total **\$7,400**, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **\$7,400**, you pay the greater of either:

- **\$4.15** for generic (including brand drugs treated as generic) and a **\$10.35** copay for all other drugs, OR
- **5%** coinsurance

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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 1-866-773-5959 (TTY: 711). Someone who speaks English 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 1-866-773-5959 (TTY: 711). 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 1-866-773-5959 (TTY: 711)。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 1-866-773-5959 (TTY: 711)。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 1-866-773-5959 (TTY: 711). 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 1-866-773-5959 (TTY: 711). 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 quý vị cần thông dịch viên xin gọi 1-866-773-5959 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-773-5959 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-773-5959 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.



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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 1-866-773-5959 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY: 711) 1-866-773-5959. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة 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 1-866-773-5959 (TTY: 711) 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 1-866-773-5959 (TTY: 711). 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 1-866-773-5959 (TTY: 711). 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 1-866-773-5959 (TTY: 711). 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 1-866-773-5959 (TTY: 711). 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。通訳をご用命になるには、1-866-773-5959 (TTY: 711) にお電話ください。日本語を話す人が支援いたします。これは無料のサービスです。

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You can see your plan's drug formulary at www.humana.com/medicaredruglist or call us at the number listed at the beginning of this booklet and we will send you one.



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