2024

Summary of Benefits

Humana Group Medicare Advantage HMO-POS Plan
HMO-POS 055/101

ELA - Rubi Max

ADMINISTRACION DE
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Contrato Número

Humana.

Our service area includes all municipalities in Puerto Rico.

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

Find out more about the Humana Group Medicare Advantage HMO-POS 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-POS plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Plan name:

Humana Group Medicare Advantage HMO-POS 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. – 8 p.m.

Call Saturday - 7 a.m. - 6 p.m.

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

As a member you must select an in-network doctor in your service area listed in this document to act as your Primary Care Provider (PCP). Humana Group Medicare Advantage HMO-POS plan has a network of doctors, hospitals, and other providers. If you use providers who aren't in our network, the plan may not pay for these services. For more information, please call Group Medicare Customer Care.

Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. You may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider.

Under this plan, you have Point-of-Service (POS) option, which allows you to receive select services outside of the plan provider network. Under the POS option for out of network services, you have a maximum benefit limit of $5,000 per year for some outpatient services and may require higher cost-sharing than you would pay when using network providers. Please review your Evidence of Coverage for more information.

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A healthy partnership

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

Monthly Premium, Deductible and Limits

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.
Part B premium reduction	Your plan will reduce your Monthly Part B premium by up to **$85**.
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** **$1,500** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; Dental Services (Routine); Fitness Program; Health Education Services; Meal Benefit; Smoking Cessation (Additional); Vision Services (Routine) 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.
Maximum Plan Benefit Coverage	**$5,000** out-of-network Annual Maximum Coverage toward select services outside of the plan provider network. Outpatient services include PCP, Specialist and Labs.

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-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.	**$0** per admit	Not Covered
OUTPATIENT HOSPITAL COVERAGE		
Outpatient hospital visits	**$0** copay	Not Covered
Outpatient lab services	**$0** copay	**20%** of the cost
Ambulatory surgical center	**$0** copay	Not Covered
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**20%** of the cost
Specialists	**$0** copay	**20%** of the cost
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**	**Covered at no cost**
EMERGENCY CARE		
Emergency room 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.	**$15** copay for Medicare-covered emergency room visit(s)	Not Covered
Urgently needed services Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$0** copay	Not Covered

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic radiology	**$0** copay	Not Covered
Lab services	**$0** copay	**20%** of the cost
Diagnostic tests and procedures	**$0** copay	Not Covered
Outpatient X-rays	**$0** copay	Not Covered
Radiation therapy	**$0** copay	Not Covered
HEARING SERVICES		
Medicare-covered hearing	**$0** copay	Not Covered
Routine hearing	**$0** copay for fitting/evaluation, routine hearing exams up to 1 per year. **$1,250** maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year.	Not Covered
DENTAL SERVICES		
Medicare-covered dental	**$0** 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)	Not Covered
Routine dental	**0%** of the cost for bitewing x-rays up to 1 set(s) every 2 years. **0%** of the cost for periodontal surgery up to 1 per quadrant every 3 years. **0%** of the cost for amalgam and/or composite filling up to 1 per tooth every 3 years. **0%** of the cost for comprehensive oral exam, cone beam CT imaging, panoramic film up to 1 every 3 years. **0%** of the cost for crown, implant supported prosthetics up to 1 per tooth every 5 years.	Not Covered

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	IN-NETWORK	OUT-OF-NETWORK
	0% of the cost for bridges, complete dentures, complete or partial denture reline, partial dentures up to 1 every 5 years. **0%** of the cost for implant services, other restorative services - core buildup and prefabricated post and core up to 1 per tooth per lifetime. **0%** of the cost for scaling and root planing (deep cleaning) up to 1 per quadrant per year. **0%** of the cost for periodontal debridement up to 1 per year. **0%** of the cost for pulp vitality test up to 2 per quadrant per year. **0%** of the cost for periodic oral exam, periodontal maintenance, prophylaxis (cleaning) up to 2 per year. **0%** of the cost for complete or partial denture repair up to 3 per year. **0%** of the cost for intraoral x-rays up to 6 per year. **0%** of the cost for adjustments to dentures, extractions, root canal up to unlimited per year. **$3,000** maximum benefit coverage amount per year for implant services and implant supported prosthetics.	

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Limitations and exclusions may apply. 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 dental coverage limit. 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 dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule (but coinsurance payment still applies).

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at **Humana.com > Find a doctor > Select the Dentist icon from the menu > From the Distance drop down select the preferred distance > Enter Zip code > From the look up method select All Dental Networks > Then select HumanaDental Medicare.**		
VISION SERVICES		
Medicare-covered vision services	**$0** copay (services include diagnosis and treatment of diseases and injuries of the eye)	Not Covered
Medicare-covered diabetic eye exam	**$0** copay	Not Covered
Medicare-covered glaucoma screening	**$0** copay	Not Covered
Medicare-covered eyewear (post-cataract)	**$0** copay	Not Covered
Routine vision	**$0** copay for routine exam (includes refraction) up to 1 per year. **$1,000** 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).	Not Covered

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH SERVICES		
Inpatient 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.	**$0** per admit	Not Covered
Outpatient group and individual therapy visits	**Outpatient therapy visit:** **$0** copay **Partial Hospitalization:** **$0** copay	**Outpatient therapy visit:** Not Covered **Partial Hospitalization:** Not Covered
SKILLED NURSING FACILITY		
Our plan covers up to 100 days in a SNF. No 3-day hospital stay is required. Plan pays $0 after 100 days.	**$0** copay per day for days 1-100	Not Covered
PHYSICAL THERAPY		
	$0 copay	Not Covered
AMBULANCE		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	**$0** copay	Not Covered
TRANSPORTATION		
	$0 copay for plan approved location up to unlimited one-way trip(s) per year by car, van, wheelchair access vehicle.	Not Covered
PART B PRESCRIPTION DRUGS		
ADMINISTRACION DE SEGUROS DE SALUD	**$0** copay or **0%** of the cost	Not Covered

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUPUNCTURE SERVICES		
Medicare-covered acupuncture visit(s) for chronic low back pain Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements.	**$0** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.	Not Covered
Routine acupuncture	**$0** copay for acupuncture visits up to 6 visit(s) per year.	Not Covered
ALLERGY		
Allergy shots & serum	**$0** copay	Not Covered
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	**$0** copay	Not Covered
Routine chiropractic visit(s)	**$0** copay for routine chiropractic visits up to 15 visit(s) per year.	Not Covered
DIABETES MANAGEMENT TRAINING		
	$0 copay	Not Covered
FOOT CARE (PODIATRY)		
Medicare-covered foot care	**$0** copay	Not Covered
HOME HEALTH CARE		
	$0 copay	Not Covered
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**0%** of the cost	Not Covered
Medical supplies	**0%** of the cost	Not Covered
Prosthetics (artificial limbs or braces)	**0%** of the cost	Not Covered
Diabetes monitoring supplies	**0%** of the cost	Not Covered

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT SUBSTANCE ABUSE		
Outpatient group and individual substance abuse treatment visits	**Outpatient therapy visit:** **$0** copay **Partial Hospitalization:** **$0** copay	**Outpatient therapy visit**: Not Covered **Partial Hospitalization:** Not Covered
HUMANA EXTRA DEBIT CARD		
	Members who are diagnosed with a chronic health condition will receive **$25** loaded on a debit card every month to use toward needed goods and services and pay monthly expenses. Unused funds will roll over to the next month and expire at the end of the plan year.	
EXTENDED OVER-THE-COUNTER (OTC) FOR ELDERLY HOME CARE		
	$200 maximum benefit coverage amount per month for underpads, disposable gloves, wipes, creams and lotions to prevent dry/cracked skin and decrease risk of ulcers, nutritional drinks through contracted provider. Members must meet medical criteria. Brands according to contracted provider.	
REHABILITATION SERVICES		
Occupational and speech therapy	**$0** copay	Not Covered
Cardiac rehabilitation	**$0** copay	Not Covered
Pulmonary rehabilitation	**$0** copay	Not Covered
RENAL DIALYSIS		
Renal dialysis	**$0** copay	Not Covered
Kidney disease education services	**$0** copay	Not Covered

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Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered
Specialist	**$0** copay	Not Covered
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered
ADULT DIAPERS		
	$0 copay for adult diapers (briefs, pull-ups) up to two (s) boxes every month. Members must meet medical criteria. Prior authorization is required. Brand according to contracted provider. Quantity varies by size.	
HUMANA SPENDING ACCOUNT CARD		
Over-the-Counter (OTC) Allowance The allowance is available to use at the beginning of every quarter.	**$200** quarterly allowance on a prepaid card to buy approved over-the-counter health and wellness products at participating retail locations. Allowance amount cannot be combined with other allowances which may be on the card. Unused amount expires at the end of the quarter.	

Each allowance is separate from any allowance listed. Allowances shown are accessed by using this card.

The **Humana Spending Account Card** is what you use for spending card allowances included in this plan. If your previous plan had a Humana Spending Account Card, please keep using the same card. If your previous plan did not have a Humana Spending Account Card, please activate your card as soon as you receive it in the mail.
Please keep this card even after the allowance is spent as future allowance amounts will be added to this card.

- Humana is not responsible for funds lost due to lost or stolen cards.
- Please see the back of your card for more information.
- Allowance amounts cannot be combined with other benefit allowances.
- Limitations and restrictions may apply.

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Additional Benefits Continued

	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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Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, 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.

Auxiliary aids and services, free of charge, are available to you. 1-866-773-5959 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

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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（听障专线：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（聽障專線：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 quí vị cần thông dịch viên xin gọi 1-866-773-5959 (TTY: 711) 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 1-866-773-5959 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 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.

Form CMS-10802 (Expires 12/31/25)

Form Approved OMB# 0938-1421

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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 بخطتنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-773-5959 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

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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-POS 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.

The Part B Giveback Benefit pays part or all of your Part B premium and the amount may change based on the amount you pay for Part B.

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Humana.com

2024

Prescription Drug

Summary of Benefits

Humana Group Medicare Advantage Plan
Rx 143

ELA - Rubi Max

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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 **$5,030**. 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)	**$0** copay	**$0** 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)	**$0** copay	**$0** 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 GRP**29**.

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you (even if you haven't paid your deductible, if applicable). Call Customer Care for more information.

Important Message About What You Pay for Insulin – You won't pay more than **$0** for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

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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 **$5,030**. 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 **$8,000** for 2024.
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 **$5,030**. 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 **$8,000**, 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 **$8,000**, you have a **$0** copayment.

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Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, 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.

Auxiliary aids and services, free of charge, are available to you. 1-866-773-5959 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

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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（听障专线：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（聽障專線：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 quí vị cần thông dịch viên xin gọi 1-866-773-5959 (TTY: 711) 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 1-866-773-5959 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 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.

Form CMS-10802 (Expires 12/31/25)
Form Approved OMB# 0938-1421

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Find out **more**

You can see your plan's pharmacy directory at **https://www.humana.com/finder/pharmacy/** or call us at the number listed at the beginning of this booklet and we will send you one.

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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Humana®

Humana.com

2024

Summary of Benefits

Humana Group Medicare Advantage HMO-POS Plan
HMO-POS 055/100

ELA - Zafiro

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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-POS** Plan.

Find out more about the Humana Group Medicare Advantage HMO-POS 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-POS plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Plan name:

Humana Group Medicare Advantage HMO-POS 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. – 8 p.m.

Call Saturday - 7 a.m. - 6 p.m.

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

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As a member you must select an in-network doctor in your service area listed in this document to act as your Primary Care Provider (PCP). Humana Group Medicare Advantage HMO-POS plan has a network of doctors, hospitals, and other providers. If you use providers who aren't in our network, the plan may not pay for these services. For more information, please call Group Medicare Customer Care.

Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. You may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider.

Under this plan, you have Point-of-Service (POS) option, which allows you to receive select services outside of the plan provider network. Under the POS option for out of network services, you have a maximum benefit limit of $5,000 per year for some outpatient services and may require higher cost-sharing than you would pay when using network providers. Please review your Evidence of Coverage for more information.

A healthy partnership

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

Monthly Premium, Deductible and Limits

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.
Part B premium reduction	Your plan will reduce your Monthly Part B premium by up to **$164.90**.
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** **$1,500** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; Dental Services (Routine); Fitness Program; Health Education Services; Meal Benefit; Smoking Cessation (Additional); Vision Services (Routine) 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.
Maximum Plan Benefit Coverage	**$5,000** out-of-network Annual Maximum Coverage toward select services outside of the plan provider network. Outpatient services include PCP, Specialist and Labs.

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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. Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a referral and/or prior authorization from the plan .*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-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.	**$0** per admit	Not Covered
OUTPATIENT HOSPITAL COVERAGE		
Outpatient hospital visits	**$0** to **$15** copay	Not Covered
Outpatient lab services	**$0** copay	**20%** of the cost
Ambulatory surgical center	**$15** copay	Not Covered
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**20%** of the cost
Specialists	**$0** copay	**20%** of the cost
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**	**Covered at no cost**
EMERGENCY CARE		
Emergency room 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.	**$25** copay for Medicare-covered emergency room visit(s)	Not Covered
Urgently needed services Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$0** copay	Not Covered

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic radiology	**$0** to **$7** copay	Not Covered
Lab services	**$0** copay	**20%** of the cost
Diagnostic tests and procedures	**$0** to **$7** copay	Not Covered
Outpatient X-rays	**$0** copay	Not Covered
Radiation therapy	**$0** to **$7** copay	Not Covered
HEARING SERVICES		
Medicare-covered hearing	**$0** copay	Not Covered
Routine hearing	**$0** copay for fitting/evaluation, routine hearing exams up to 1 per year. **$1,250** maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year.	Not Covered
DENTAL SERVICES		
Medicare-covered dental	**$0** 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)	Not Covered
Routine dental	**0%** of the cost for bitewing x-rays up to 1 set(s) every 2 years. **0%** of the cost for periodontal surgery up to 1 per quadrant every 3 years. **0%** of the cost for amalgam and/or composite filling up to 1 per tooth every 3 years. **0%** of the cost for comprehensive oral exam, cone beam CT imaging, panoramic film up to 1 every 3 years. **0%** of the cost for crown, implant supported prosthetics up to 1 per tooth every 5 years.	Not Covered

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	IN-NETWORK	OUT-OF-NETWORK
	0% of the cost for bridges, complete dentures, complete or partial denture reline, partial dentures up to 1 every 5 years. **0%** of the cost for implant services, other restorative services - core buildup and prefabricated post and core up to 1 per tooth per lifetime. **0%** of the cost for scaling and root planing (deep cleaning) up to 1 per quadrant per year. **0%** of the cost for periodontal debridement up to 1 per year. **0%** of the cost for pulp vitality test up to 2 per quadrant per year. **0%** of the cost for periodic oral exam, periodontal maintenance, prophylaxis (cleaning) up to 2 per year. **0%** of the cost for complete or partial denture repair up to 3 per year. **0%** of the cost for intraoral x-rays up to 6 per year. **0%** of the cost for adjustments to dentures, extractions, root canal up to unlimited per year. **$10,000** maximum benefit coverage amount per year for adjustments to dentures, bridges, complete dentures, complete or partial denture reline, complete or partial denture repair, crown, implant services, implant supported prosthetics, other restorative services - core buildup and prefabricated post and core, partial dentures comprehensive benefits.	

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Limitations and exclusions may apply. 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

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK

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

The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at **Humana.com > Find a doctor > Select the Dentist icon from the menu > From the Distance drop down select the preferred distance > Enter Zip code > From the look up method select All Dental Networks > Then select HumanaDental Medicare.**

VISION SERVICES		
Medicare-covered vision services	**$0** copay (services include diagnosis and treatment of diseases and injuries of the eye)	Not Covered
Medicare-covered diabetic eye exam	**$0** copay	Not Covered
Medicare-covered glaucoma screening	**$0** copay	Not Covered
Medicare-covered eyewear (post-cataract)	**$0** copay	Not Covered
Routine vision	**$0** copay for routine exam (includes refraction) up to 1 per year. **$850** 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).	Not Covered

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH SERVICES		
Inpatient 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.	**$0** per admit	Not Covered
Outpatient group and individual therapy visits	**Outpatient therapy visit:** **$0** copay **Partial Hospitalization:** **$0** copay	**Outpatient therapy visit:** Not Covered **Partial Hospitalization:** Not Covered
SKILLED NURSING FACILITY		
Our plan covers up to 100 days in a SNF. No 3-day hospital stay is required. Plan pays $0 after 100 days.	**$0** copay per day for days 1-100	Not Covered
PHYSICAL THERAPY		
	$0 to **$15** copay	Not Covered
AMBULANCE		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	**$0** copay	Not Covered
TRANSPORTATION		
	$0 copay for plan approved location up to 48 one-way trip(s) per year by car, van, wheelchair access vehicle.	Not Covered
PART B PRESCRIPTION DRUGS		
	$0 copay or **0%** of the cost	Not Covered

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUPUNCTURE SERVICES		
Medicare-covered acupuncture visit(s) for chronic low back pain Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements.	**$0** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.	Not Covered
Routine acupuncture	**$0** copay for acupuncture visits up to 6 visit(s) per year.	Not Covered
ALLERGY		
Allergy shots & serum	**$0** copay	Not Covered
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	**$0** copay	Not Covered
Routine chiropractic visit(s)	**$0** copay for routine chiropractic visits up to 15 visit(s) per year.	Not Covered
DIABETES MANAGEMENT TRAINING		
	$0 copay	Not Covered
FOOT CARE (PODIATRY)		
Medicare-covered foot care	**$0** copay	Not Covered
HOME HEALTH CARE		
	$0 copay	Not Covered
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**5%** of the cost	Not Covered
Medical supplies	**0%** of the cost	Not Covered
Prosthetics (artificial limbs or braces)	**5%** of the cost	Not Covered
Diabetes monitoring supplies	**0%** of the cost	Not Covered

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT SUBSTANCE ABUSE		
Outpatient group and individual substance abuse treatment visits	**Outpatient therapy visit:** **$0** copay **Partial Hospitalization:** **$25** copay	**Outpatient therapy visit**: Not Covered **Partial Hospitalization:** Not Covered
HUMANA EXTRA DEBIT CARD		
	Members who are diagnosed with a chronic health condition will receive **$50** loaded on a debit card every month to use toward needed goods and services and pay monthly expenses. Unused funds will roll over to the next month and expire at the end of the plan year.	
REHABILITATION SERVICES		
Occupational and speech therapy	**$0** to **$15** copay	Not Covered
Cardiac rehabilitation	**$0** to **$15** copay	Not Covered
Pulmonary rehabilitation	**$0** to **$15** copay	Not Covered
RENAL DIALYSIS		
Renal dialysis	**$0** copay	Not Covered
Kidney disease education services	**$0** copay	Not Covered
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered
Specialist	**$0** copay	Not Covered
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered

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Additional Benefits

	IN-NETWORK
HUMANA SPENDING ACCOUNT CARD	
Over-the-Counter (OTC) Allowance The allowance is available to use at the beginning of every month.	**$25** monthly allowance on a prepaid card to buy approved over-the-counter health and wellness products at participating retail locations. Allowance amount cannot be combined with other allowances which may be on the card. Unused amount rolls over to the next month and expires at the end of the plan year.

Each allowance is separate from any allowance listed. Allowances shown are accessed by using this card.

The **Humana Spending Account Card** is what you use for spending card allowances included in this plan. If your previous plan had a Humana Spending Account Card, please keep using the same card. If your previous plan did not have a Humana Spending Account Card, please activate your card as soon as you receive it in the mail.
Please keep this card even after the allowance is spent as future allowance amounts will be added to this card.

- Humana is not responsible for funds lost due to lost or stolen cards.
- Please see the back of your card for more information.
- Allowance amounts cannot be combined with other benefit allowances.
- Limitations and restrictions may apply.

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Additional Benefits Continued

	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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Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, 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.

Auxiliary aids and services, free of charge, are available to you. 1-866-773-5959 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

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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（听障专线：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（聽障專線：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 quí vị cần thông dịch viên xin gọi 1-866-773-5959 (TTY: 711) 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 1-866-773-5959 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 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.

Form CMS-10802 (Expires 12/31/25) Form Approved OMB# 0938-1421

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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 بخطتنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-773-5959 (TTY: 711). 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.

Portuguese: 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: 当社の健康保険と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をご用意しています。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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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-POS 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.

The Part B Giveback Benefit pays part or all of your Part B premium and the amount may change based on the amount you pay for Part B.

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Humana®

Humana.com

2024

Prescription Drug

Summary of Benefits

Humana Group Medicare Advantage Plan
Rx 419

ELA - Zafiro

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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 **$5,030**. 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)	**$3** copay	**$3** 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)	**$6** copay	**$6** 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 GRP**29**.

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you (even if you haven't paid your deductible, if applicable). Call Customer Care for more information.

Important Message About What You Pay for Insulin – You won't pay more than **$0** for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

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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 **$5,030**. 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 **$8,000** for 2024.
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 **$5,030**. 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 **$8,000**, 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 **$8,000**, you have a **$0** copayment.

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Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, 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.

Auxiliary aids and services, free of charge, are available to you. 1-866-773-5959 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

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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（听障专线：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（聽障專線：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 quí vị cần thông dịch viên xin gọi 1-866-773-5959 (TTY: 711) 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 1-866-773-5959 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 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 .

Form CMS-10802 (Expires 12/31/25)

Form Approved OMB# 0938-1421

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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 بخطتنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-773-5959 (TTY: 711). 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.

Portuguese: 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: 当社の健康保険と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をご用意しています。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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Find out **more**

You can see your plan's pharmacy directory at **https://www.humana.com/finder/pharmacy/** or call us at the number listed at the beginning of this booklet and we will send you one.

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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Humana is a Medicare Advantage HMO, PPO organization and a stand-alone prescription drug plan with a Medicare contract. Enrollment in any Humana plan depends on contract renewal.

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