2017

Summary of Benefits

Humana Gold Plus®
SNP-DE H6859-008 (HMO SNP)

Pennsylvania
Select counties in Pennsylvania

Humana®

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Our service area includes the following county/counties in Pennsylvania: Berks, Bucks, Chester, Cumberland, Dauphin, Delaware, Lackawanna, Lancaster, Lehigh, Luzerne, Montgomery, Northampton, Perry, Philadelphia, Wyoming, PA;.

Let's talk about **Humana Gold Plus®**

SNP-DE H6859-008 (HMO SNP)

Find out more about the Humana Gold Plus SNP-DE H6859-008 (HMO SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus SNP-DE H6859-008 (HMO SNP) is a Coordinated Care plan with a Medicare contract and a contract with the Pennsylvania Department of Human Services (DHS). Enrollment in this Humana plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, ask us for the "Evidence of Coverage" or you will receive one after you enroll.

As a member you must select an in-network doctor to act as your Primary Care Physician (PCP). Humana Gold Plus SNP-DE H6859-008 (HMO SNP) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services. You have access to Care Managers. Care Managers are nurses or care coordinators who support your health and well-being by providing additional services including: acute- and chronic-care management, telephonic and in-person health support; assistance in coordinating Medicare and Medicaid benefits, educational resources and workshops and support for families and caregivers.

To be eligible

To enroll in Humana Gold Plus SNP-DE H6859-008 (HMO SNP), a Dual Eligible Special Needs Plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B, live in our service area and also receive certain levels of assistance from the Pennsylvania Medical Assistance Program (Medicaid). If you receive both Medicare and Medicaid benefits, this means you are a dual eligible.

Humana Gold Plus SNP-DE H6859-008 (HMO SNP) may enroll dual eligibles who are SLMB Plus, QMB Plus, QMB and FBDE.

Plan name:

Humana Gold Plus SNP-DE H6859-008 (HMO SNP)

More about Humana Humana Gold Plus SNP-DE H6859-008 (HMO SNP)

As a member of this plan, you will not be responsible for cost sharing for plan benefits. The Comprehensive Benefit Chart shows the benefits you will receive from Humana and how Medicaid covers your cost sharing for those plan benefits. The chart also lists some benefits you could receive from Medicaid if you are eligible for full Medicaid benefits. If you are entitled to Medicare benefits, your care coordinator will work with you to assist you in understanding and accessing the Medicare and Medicaid benefits you may be entitled to.

How to reach us:

If you have questions about your benefits or your level of eligibility for assistance from Medicaid, you should contact Humana's customer service department or your state Medicaid office for further details.

If you're a member of this plan, call toll-free: **1-800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-833-2364 (TTY: 711)**.

October 1 - February 14:
Call 7 days a week from 8 a.m. - 8 p.m.

February 15 - September 30:
Call Monday - Friday, 8 a.m. - 8 p.m.

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

For the most current Pennsylvania Medicaid coverage information, please visit the Pennsylvania Medicaid website at http://www.dhs.pa.gov/ or call the Medicaid Hotline at 1-(800) 692-7462.

A healthy partnership

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

This document is available in other formats such as Braille and large print. This information is available for free in other languages. Please contact a licensed Humana sales agent at 1-800-833-2364 (TTY: 711). Esta información está disponible gratuitamente en otros idiomas. Póngase en contacto con un agente de ventas certificado de Humana al 1-800-833-2364 (TTY: 711).

Monthly Premium, Deductible and Limits

Monthly premium	**$0** copay
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	This plan does not have a deductible.
Maximum out-of-pocket responsibility	**$6,700** in-network The most you pay for copays, coinsurance and other costs for medical services for the year.

Covered Medical and Hospital Benefits

For members protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copays and deductibles for Original Medicare covered services up to the Medicaid allowed rate.

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
ACUTE INPATIENT HOSPITAL CARE		
	$0 copay	• No limits • **$0** copay for children under 18 years of age • Sliding scale copay from **$0.65** - **$3.80** for individuals 18 years of age and older
DOCTOR OFFICE VISITS		
Primary care Physician (PCP)	**$0** copay	• No limits • **$0** copay for children under 18 years of age • Sliding scale copay from **$0.65** - **$3.80** for individuals 18 years of age and older
Specialists	**$0** copay	• No limits • **$0** copay for children under 18 years of age • Sliding scale copay from **$0.65** - **$3.80** for individuals 18 years of age and older

Your plan may require approval in advance from your primary care physician (PCP) before you see a specialist or certain other providers. This is called a "referral." If you don't have a referral, you may have to pay for these services yourself.
Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
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** when you see an in-network provider.	• Covered services include the following: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM). • **$0** copay for children under 18 years of age • Sliding scale copay from **$0** - **$3.80** for individuals 18 years of age and older
EMERGENCY CARE		
Emergency room If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	**$0** copay	• No limits • **$0** copay
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	• No limits • **$0** copay
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic Mammography	**$0** copay	• No limits • **$0** copay

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Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
Diagnostic radiology	**$0** copay	• No limits • **$0** copay for children under 18 years of age • **$1** for individuals 18 years of age and older for total or technical component
Lab services	**$0** copay	• No limits • **$0** copay for children under 18 years of age • **$1** for individuals 18 years of age and older for total or technical component
Diagnostic tests and procedures	**$0** copay	• No limits • **$0** copay for children under 18 years of age • **$1** for individuals 18 years of age and older for total or technical component
Outpatient X-rays	**$0** copay	• No limits • **$0** copay for children under 18 years of age • **$1** for individuals 18 years of age and older for total or technical component
Radiation Therapy	**$0** copay	• No limits • **$0** copay for children under 18 years of age • **$1** for individuals 18 years of age and older for total or technical component
HEARING SERVICES		
Medicare covered hearing	**$0** copay	• Hearing aids are not covered for individuals 18 years of age and older • Hearing aids are covered for children under 18 years of age • **$0** copay for children under 18 years of age • Sliding scale copay from **$0.65** - **$3.80** for individuals 18 years of age and older
Routine hearing	• **$0** copayment for routine hearing test & fitting/evaluation for hearing aid up to 1 per year. • **$500** maximum benefit coverage amount per ear for Hearing Aids (all types) up to 1 per ear per year.	

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Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
DENTAL SERVICES		
Medicare covered dental	**$0** copay	• Diagnostic, preventive, restorative, and surgical dental procedures, prosthodontics and sedation. • 1 exam/prophylaxis every 180 days • Crowns, periodontics and endodontics only via approved benefit limit exception. • **$0** copay for children under 18 years of age • Sliding scale copay from **$0.65** - **$3.80** for individuals 18 years of age and older
Routine dental	• **$0** copayment for Amalgam Filling, Bitewing X-rays, Composite Filling, Denture Reline, Extractions, Periodic Oral Exam or Comprehensive Oral Evaluation, Prophylaxis (cleaning) up to 1 per year. • **$0** copayment for Necessary Anesthesia with Covered Service up to unlimited per year.	
VISION SERVICES		
Medicare covered vision services	**$0** copay	• 2 visits (exams) per calendar year • 4 eyeglass lenses per calendar year (limited to individuals with aphakia) • 2 eyeglass frames per calendar year (limited to individuals with aphakia) • 4 contact lenses per calendar year (limited to individuals with aphakia) • **$0** copay for children under 18 years of age • Sliding scale copay from **$0.65** - **$3.80** for individuals 18 years of age and older
Glaucoma screening	**$0** copay	
Eyewear (post-cataract)	**$0** copay	
Routine vision	• **$0** copayment for Routine Exam, which includes refraction, up to 1 per year. • **$200** maximum benefit coverage amount per year for Contact Lenses or Eyeglasses - Lenses and Frames. • Includes ultraviolet protection and scratch resistant coating.	

Your plan may require approval in advance from your primary care physician (PCP) before you see a specialist or certain other providers. This is called a "referral." If you don't have a referral, you may have to pay for these services yourself.
Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$0** copay	• No limits for inpatient and outpatient mental health services • **$0** copay for inpatient and outpatient mental health services for children under 18 years of age • **$0.50** per unit copay for outpatient group and individual therapy for individuals 18 years of age and older • **$3** per day up to **$21.00** per admission for inpatient mental health services for individuals 18 years of age and older
Outpatient group and individual therapy visits	**$0** copay	
SKILLED NURSING FACILITY		
Your plan covers up to 100 days in a SNF	**$0** copay	• No limits • **$0** copay
REHABILITATION SERVICES		
Physical, occupational and speech therapy	**$0** copay	• Only when provided by a hospital, outpatient clinic, or home health provider. • **$0** copay for children under 18 years of age • **$0** copay for individuals 18 years of age and older when provided by a home health provider • Sliding scale copay from **$0.65** - **$3.80** for individuals 18 years and older when provided by a hospital or outpatient clinic
Cardiac and pulmonary rehabilitation	**$0** copay	• No limits • **$0** copay for children under 18 years of age • Sliding scale copay from **$0.65** - **$3.80** for individuals 18 years of age and older

Your plan may require approval in advance from your primary care physician (PCP) before you see a specialist or certain other providers. This is called a "referral." If you don't have a referral, you may have to pay for these services yourself.
Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
AMBULANCE		
Ambulance (ground)	**$0** copay	• No limits • **$0** copay
Ambulance (air)	**$0** copay	
TRANSPORTATION		
	$0 copay for up to 24 one-way trips to plan approved locations. Not to exceed 25 miles per trip.	• Provides transportation to and from medical appointments for beneficiaries who do not have transportation available to them. • **$0** copay
FOOT CARE (PODIATRY)		
Medicare covered foot care	**$0** copay	• No limits for podiatrist services. • **$0** copay for children under 18 years of age • Sliding scale copay from **$0.65** - **$3.80** for individuals 18 years of age and older
Routine foot care	**0%** per visit for up to 6 visits	• No limits for podiatrist services. • **$0** copay for children under 18 years of age • Sliding scale copay from **$0.65** - **$3.80** for individuals 18 years of age and older
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**$0** copay	• No limits • **$0** copay for children under 18 years of age • **$0** copay for rental of durable medical equipment, otherwise sliding scale copay from **$0.65** - **$3.80** for individuals 18 years of age and older
Medical Supplies	**$0** copay	• No limits • **$0** copay for children under 18 years of age • Sliding scale copay from **$0.65** - **$3.80** for individuals 18 years of age and older

Your plan may require approval in advance from your primary care physician (PCP) before you see a specialist or certain other providers. This is called a "referral." If you don't have a referral, you may have to pay for these services yourself.
Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
Prosthetics (artificial limbs or braces)	**$0** copay	• Orthopedic shoes and hearing aids are not covered • Coverage of low vision aids is limited to 1 per 2 calendar years • Coverage for an eye occluder is limited to 1 per calendar year. • **$0** copay for children under 18 years of age • Sliding scale copay from **$0.65** - **$3.80** for individuals 18 years of age and older
Diabetes monitoring supplies	**$0** copay	• No limits • **$0** copay for children under 18 years of age • Sliding scale copay from **$0.65** - **$3.80** for individuals 18 years of age and older
FITNESS AND WELLNESS		
	SilverSneakers® Fitness Program - Basic fitness center membership including fitness classes. The plan covers more benefits that promote health and well-being. To see more benefits, check out "More benefits with your plan," listed later in this document.	• Not provided

Prescription Drug Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
MEDICARE PART B DRUGS		
Chemotherapy drugs	**$0** copay	
Other part B drugs	**$0** copay	

Your plan may require approval in advance from your primary care physician (PCP) before you see a specialist or certain other providers. This is called a "referral." If you don't have a referral, you may have to pay for these services yourself.
Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
PRESCRIPTION DRUGS		
Medicare Part D Drugs	See chart below for plan coverage information for prescription drugs	Medicaid may cover some over-the-counter drugs that are not covered by Part D. Contact your Medicaid agency for questions on drug coverage. • **$1** - **$3** copay for Medicaid covered drugs not covered by a Medicare.
Initial coverage (after you pay your deductible, if applicable)		
30-day supply		
For generic drugs (including brand drugs treated as generic), either:	**$0** copay; or **$1.20** copay; or **$3.30** copay	
For all other drugs, either:	**$0** copay; or **$3.70** copay; or **$8.25** copay	
90-day supply		
For generic drugs (including brand drugs treated as generic), either:	**$0** copay; or **$1.20** copay; or **$3.30** copay	
For all other drugs, either:	**$0** copay; or **$3.70** copay; or **$8.25** copay	

Specialty drugs are limited to a 30 day supply.

Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 Monday — Friday, 7 am. — 7 p.m. TTY users should call 1-800-325-0778. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our "Evidence of Coverage" online.

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

You may get drugs from an out-of-network pharmacy but may pay more than you pay at an in-network pharmacy.

Days' Supply Available
Unless otherwise specified, you can get your Part D medicine in the following days' supply amounts:
- One month supply (up to 30 days)*

- Two month supply (31-60 days)
- Three month supply (61-90 days)

*Long term care pharmacy (one month supply = 31 days)

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$4,950**, you pay nothing for all drugs.

Additional Medicaid Covered Services

Dual eligible members who meet financial criteria for full Medicaid coverage may also be eligible to receive all Medicaid services not covered by Medicare. Humana Gold Plus may also offer coverage for these services. The benefits described below are covered by Medicaid. The benefits described in the Covered Medical and Hospital Benefits section of the Summary of Benefits are covered by Medicare. For each benefit listed below, you can see what the Pennsylvania Department of Human Services (DHS) covers and what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility. If you have questions about your Medicaid eligibility and what benefits you are entitled to call 1-(800) 692-7462.

BENEFITS	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID STATE PLAN
PRODUCTS AND DEVICES		
Dentures	See “Dental” benefit in the “Covered Medical and Hospital Benefits” chart above	• Covered for children up to age 21 • Covered for adults age 21 and older with the following limitations: – Prior authorization required for complete or partial dentures – Dentures will be limited to one full or partial upper arch and one full or partial lower arch, or one complete set of dentures per lifetime – Denture relines, either full or partial, limited to one arch every two years • **$0** copay for children under 18 years of age • Sliding scale copay from **$0.65** - **$3.80** for individuals 18 years of age and older

Eyeglasses	See "Vision" benefit in the "Covered Medical and Hospital Benefits" chart above	• Covered for children under 21 years of age • Covered for individuals 21 and older with aphakia with the following limits: • 4 eyeglass lenses per calendar year • 4 contact lenses per calendar year • 2 eyeglass frames per calendar year • **$0** copay for children under 18 years of age • Sliding copay from **$0.65** - **$3.80** for individuals 18 years of age and older
Hearing Aids	See "Hearing" benefit in the "Covered Medical and Hospital Benefits" chart above	• Covered for children under 21 years of age • **$0** copay for children under 18 years of age • Sliding copay from **$0.65** - **$3.80** for individuals 18 years of age and older
TRANSPORTATION		
Non-Emergency Medical Transportation Services	See "Transportation" benefit in the "Covered Medical and Hospital Benefits" chart above	• Unlimited transportation services are available to beneficiaries who have no other means of transportation to or from a source of necessary medical care or to obtain prescription drugs through counties and prime contractors funded by the Public Assistance Transportation Block Grant. • **$0** copay
INPATIENT LONG TERM CARE SERVICES		
Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services in Institutions for Mental Diseases (IMD), age 65 and older	Not covered	• No limits • **$0** copay
Inpatient Psychiatric Services, under age 21	See "Mental Health" benefit in the "Covered Medical and Hospital Benefits" chart above	• No limits • **$0** copay

Intermediate Care Facility Services for Individuals with Intellectual Disabilities	Not Covered	• No limits • Requires an institutional level of care • **$0** copay
Nursing Facility Services, other than in an Institution for Mental Diseases	See "Skilled Nursing" benefit in the "Covered Medical and Hospital Benefits" chart above	• No limits • **$0** copay

HOME AND COMMUNITY BASED WAIVER SERVICES

Dual eligible members, who meet the financial criteria for full Medicaid coverage, may also be eligible to receive Waiver services. Waiver services are limited to individuals who meet additional waiver eligibility criteria. For information on waiver services and eligibility, contact Medicaid at 1-(800) 692-7462 or the Aging and Disability Resource Connection at 1-866-552-4464.

The Additional Medicaid Covered Services table above reflects Medicaid services available on a fee for service basis for dual eligibles who meet the eligibility requirements for full Medicaid benefits.

The Medicaid information included in this section is current as of 7/1/2016. All Medicaid covered services are subject to change at any time. For the most current Pennsylvania Medicaid coverage information, please visit the Pennsylvania Medicaid website at http://www.dhs.pa.gov/ or call the Medicaid Hotline at 1-(800) 692-7462.

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

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

Chiropractic services
Medicare-covered Chiropractic Services:
$0 copay
Routine Chiropractic Services:
- **0%** per visit for up to 12 visits

Counseling
Member Assistance Program includes counseling by phone to help you cope with life changes, including adult care and child care issues. Online resources are also available.

Health education
One-on-one wellness coaching with email, phone and online chat options.

Meals
Well Dine Meal Program - Humana's meal program for members following an inpatient stay in the hospital or nursing facility

HumanaFirst nurse advice line
Health advice from a registered nurse, available 24 hours a day, seven days a week.

Over-the-counter allowance
$0 copay; up to **$20** monthly value for the purchase of OTC supplies from Humana Pharmacy mail delivery.

Wigs
Wigs for hair loss related to chemotherapy.

Go365™ by Humana
Rewards for completing preventive health screenings and activities.

Find out **more**

You can see our plan's **provider and pharmacy directory** at our website at **www.humana.com/members/tools** or call us at the number listed at the beginning of this booklet and we will send you one.

You can see our plan's **drug formulary** at our website at **www.humana.com/medicare/medicare_prescription_drugs/medicare_drug_tools/medicare_drug_list/** or call us at the number listed at the beginning of this booklet and we will send you one.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

To find out more about the coverage and costs of Original Medicare, look in the current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Humana has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2019 based on a review of Humana's Model of Care.

Premiums, co-pays, co-insurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for more details.

The provider/pharmacy network may change at any time. You will receive notice when necessary.

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Notes

Discrimination is Against the Law

CHA HMO, INC., CAREPLUS HEALTH PLANS, INC., HUMANA MEDICAL PLAN, INC, HUMANA HEALTH PLAN, INC., HUMANA BENEFIT PLAN OF ILLINOIS, INC., HUMANA INSURANCE COMPANY, HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC., HUMANA INSURANCE OF PUERTO RICO, INC., HUMANA MEDICAL PLAN OF UTAH, INC., HUMANA HEALTH COMPANY OF NEW YORK, INC., HUMANA HEALTH PLANS OF PUERTO RICO, INC., HUMANA EMPLOYERS HEALTH PLAN OF GEORGIA, INC., HUMANA REGIONAL HEALTH PLAN, INC. CARITEN HEALTH PLAN INC., HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC., ARCADIAN HEALTH PLAN, INC., HUMANA INSURANCE COMPANY OF NEW YORK, HUMANA WI HEALTH ORGANIZATION INSURANCE CORP, HUMANA MEDICAL PLAN OF PENNSYLVANIA, INC., HUMANA MEDICAL PLAN OF MICHIGAN, INC. ("Humana") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats
- Provides free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Dr. Michelle Griffin, PhD.

If you believe that Humana has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Dr. Michelle M. Griffin, PhD (FACHE)
Civil Rights/LEP/ADA/Section 1557 Compliance Officer: 500 W. Main Street -10th floor Louisville, Kentucky 40202 Phone: 1-877-320-1235 Fax: 877-320-1269
Email: Mgriffin5@humana.com or Accessibility@humana.com
You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Dr. Michelle Griffin PHD, Civil Rights/LEP/ADA/Section 1557 Compliance Officer is available to help you at the contact information listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Interpreter Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-457-4708 (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-457-4708 (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-457-4708（TTY: 711）。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-457-4708 (TTY: 711).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-800-457-4708 (TTY: 711)번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-457-4708 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-457-4708 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-457-4708 (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-457-4708 (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-457-4708 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-457-4708 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-457-4708 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-457-4708 (TTY: 711).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-457-4708（TTY: 711）まで、お電話にてご連絡ください。

فارسی (Farsi):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-457-4708 (رقم هاتف الصم والبكم: 711).

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-457-4708 (TTY: 711)

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-457-4708 (رقم هاتف الصم والبكم: 711).

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