2024 **Health Plan Benefits** at a Glance

HumanaChoice R7315-001 (Regional PPO) States of Alabama and Tennessee

Plan Costs	**With Medicare Only**
Monthly plan premium	$0
Medicare Part B premium reduction	Your plan will reduce your Monthly Part B premium by up to $6 but by no more than Original Medicare's Part B Premium for 2024.
Medical deductible	$250 combined The following services listed are excluded from the combined in-network and out-of-network deductible: All Services received from In-Network Providers Emergency Room Services Medicare Covered Preventive Services (including Immunizations (Flu & Pneumonia)) Services not covered by Original Medicare Urgently Needed Services at Urgent Care Centers
Annual out-of-pocket maximum	$5,900 in-network $9,550 combined in and out-of-network

Doctor Office Visits	**In-Network With Medicare only**	**Out-of-Network With Medicare only**
Primary care provider (PCP)	$10 copay	30% of the cost
Specialist	$30 copay	30% of the cost
Preventive Care		
Including: Medicare covered screenings	Covered at no cost when you see an in-network provider	Preventive screenings may have a cost share when you see an out-of-network provider.
Telehealth Services (in addition to Original Medicare)		
Primary care provider (PCP)	$0 copay	Not covered
Specialist	$30 copay	Not covered
Urgent care services	$60 copay	Not covered
Substance abuse or behavioral health services	$0 copay	Not covered

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Inpatient Care		
Acute inpatient hospital care	$280 copay per day for days 1-5 $0 copay per day for days 6-90	30% of the cost
Lab Services		
Lab tests from lab facility	$0 copay	30% of the cost
Lab tests from outpatient hospital facility	$40 copay	30% of the cost
Outpatient Care		
Outpatient surgery at ambulatory surgical center	$75 copay	30% of the cost
Physical therapy at therapy facility	$20 copay	30% of the cost
X-rays at outpatient hospital facility	$50 copay	30% of the cost
Diagnostic testing at outpatient hospital facility	$50 copay	30% of the cost
Mental Health Services		
Inpatient psychiatric hospital Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	$280 copay per day for days 1-5 $0 copay per day for days 6-90	30% of the cost
Specialist's office	$30 copay	30% of the cost
Outpatient hospital	$30 copay	30% of the cost
Partial hospitalization	$30 copay	30% of the cost
Emergency Services		
Urgently needed services at an urgent care center	$60 copay	$60 copay
Ground ambulance services	$300 copay per date of service	$300 copay per date of service
Emergency room	$120 copay	$120 copay

Additional Benefits & Programs	
Mandatory supplemental dental benefit DEN354	Included - cost share may apply. Please refer to the Summary of Benefits for additional details.
Mandatory supplemental vision benefit VIS751	Included - cost share may apply. Please refer to the Summary of Benefits for additional details.
Mandatory supplemental hearing benefit HER940	Included - cost share may apply. Please refer to the Summary of Benefits for additional details.
Over-the-Counter (OTC) mail order	**$100** monthly allowance to buy approved over-the-counter health and wellness products available through our OTC Mail Order provider. Unused amount expires at the end of the month.
NationsMarket® Fresh, Prepared meal program	Included
SilverSneakers® fitness program	Included

If you have questions and are a Humana member, please contact Customer Care at 1-800-457-4708 (TTY: 711).

If you are not currently a Humana member, please contact a licensed Humana sales agent at 1-844-775-9622 (TTY: 711), 8 a.m. to 8 p.m. seven days a week from Oct. 1, 2023 – Mar. 31, 2024 and Monday - Friday the rest of the year.

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

Telehealth services shown are in addition to the Original Medicare covered telehealth. Your cost may be different for Original Medicare telehealth. Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services are for informational purposes only and should not be construed as medical advice. Please refer to your Evidence of Coverage for additional details on what your plan may cover or other rules that may apply.

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

The Part B premium reduction 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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Get all your health plan details at
Humana.com/Benefits

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities.

- The following department has been designated to handle inquiries regarding Humana's non-discrimination policies: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235** (**TTY: 711)**.

Auxiliary aids and services, free of charge, are available to you. 877-320-1235 (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.

This information is available for free in other languages. Please call our customer service number at 877-320-1235 (TTY: 711). Hours of operation: 8 a.m. – 8 p.m. Eastern time.

Español (Spanish): Llame al número indicado para recibir servicios gratuitos de asistencia lingüística. **877-320-1235 (TTY: 711)**. Horas de operación: 8 a.m. a 8 p.m. hora del este.

繁體中文 (Chinese): 本資訊也有其他語言版本可供免費索取。請致電客戶服務部：**877-320-1235（聽障專線：711）**。辦公時間：東部時間上午 8 時至晚上 8 時。

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