Texas Member Handbook

Humana National Preferred Plan
Preferred Provider Organization (PPO) Plan

Insured by Humana Insurance Company

Humana®
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Insuring company statement
This Humana National Preferred Plan is a Preferred Provider Organization (PPO) plan insured by Humana Insurance Company.

Important phone numbers
For Customer Care, please call the number on your Humana member ID card. If you lose your card, please call 1-800-448-6262 (TTY: 711) to request a new card. You also can visit Humana.com to get a new card or get details about your plan.

If you prefer, write to:
Humana Insurance Company
Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

If you need to be hospitalized, your physician or the hospital must call this number for authorization: 1-800-523-0023

For details about Humana, visit Humana.com.

Responsive service
Once you are a member, when you have questions about your plan, you can call our Customer Care team toll-free at the number on the back of your Humana member ID card. The plan subscribes to the AT&T Language Line for members who don't speak English. We make every effort to answer your calls quickly. Our hours are 8 a.m. – 6 p.m., Monday – Friday.

Special needs
Humana strives to make it easy for all members to use the benefits provided by their plan. If you need help due to a disability or chronic medical problem that has affected your vision, hearing, speech or mobility, please call Customer Care at the number on the back of your Humana member ID card. If you use a TTY, call 711.

Humana.com
Information at your fingertips
MyHumana is your secure, personal online account on Humana.com. It’s one of the best ways to get information about your plan. With MyHumana, you can get answers to questions about your health plan when you want them. You can look up records 24 hours a day.

Here are some of the things you can do on MyHumana:

- Find an in-network physician
- Look at your health plan benefits
- See if a claim has been paid
- Compare costs of medical services
- Explore health and wellness information

It’s easy to register. Just have your Humana member ID card ready when you go to Humana.com. Click “Register now,” then follow the brief directions.
This document provides a brief description of the terms and conditions of the health plan. It does not include a description of all benefits, limitations and exclusions of the plan. For complete benefits, limitations and exclusions, terms and conditions of a plan, members should refer to their Certificate of Insurance. Prospective members can view a sample Certificate of Insurance on Humana.com. Plan specific information is also provided on the Summary of Benefits and Coverage (SBC). Prospective members can contact the benefits coordinator of the employer or insurance agent for a copy of the SBC. Members can access their plan specific SBC and Certificate of Insurance through MyHumana on Humana.com.

**How to use your Humana National Preferred Plan**

With the Humana National Preferred Plan, you can choose to obtain covered services from any provider either in-network or out-of-network. An in-network provider has signed an agreement with us to provide covered services to you. The amount you pay to an in-network provider for covered services will be lower than if you receive covered services from an out-of-network provider. An out-of-network provider has not signed an agreement with us and you will pay more when an out-of-network provider provides covered services to you.

Get the most from your healthcare coverage by knowing your plan and following these simple guidelines.

- Always carry your Humana member ID card and show it when you get medical care.

- You do not need to have one healthcare practitioner to coordinate your care, however, it’s always a good idea to have one physician you trust and see for your annual physical exam and who understands your overall health status. Typically, this would be a physician who is a family practitioner, pediatrician or who specializes in internal medicine. With a Humana National Preferred Plan, you can select any physician either in or out of the PPO network. Your out-of-pocket expenses will be lower by receiving care from in-network health care providers.

- If you need specialized care, you can use any in-network or out-of-network specialist or healthcare provider of your choice. Your out-of-pocket expenses will be lower by using an in-network specialist.

- Always go to the nearest emergency room (ER) in an emergency. Refer to your Certificate of Insurance for benefit information.

- Let us know immediately about changes that affect your coverage. You must tell us if you move, marry, divorce or add a child. Just call Customer Care for an enrollment change form.

Please read your Summary of Benefits and Coverage, welcome materials and your Certificate of Insurance for details to help you get the most out of your plan.

**Provider relationships**

**Our relationship with qualified providers**

Qualified providers are not our agents, employees or partners. All providers are independent contractors. Qualified providers make their own clinical judgments or give their own treatment advice without decisions made by us.
The policy will not change what is decided between you and qualified providers regarding your medical condition or treatment options. Qualified providers act on your behalf when they order services. You and your qualified provider make all decisions about your healthcare, no matter what we cover. We are not responsible for anything said or written by a qualified provider about covered services and/or what is not covered by the plan. Call our customer service department at the telephone number listed on your ID card if you have any questions.

**Our financial arrangements with in-network providers**

We have agreements with in-network providers that may have different payment arrangements.

- Many in-network providers are paid on a discounted fee-for-services basis, meaning in-network providers have agreed to be paid a set amount for each covered service given to covered persons.

- Hospitals may be paid on a Diagnosis Related Group (DRG) basis or flat-fee-per-day basis for services provided to covered persons while hospital confined. Outpatient services are usually paid on a flat fee per service or procedure or a discount from normal charges.

- Some in-network providers may have capitation agreements, meaning the in-network provider is paid a set dollar amount each month to care for each covered person no matter how many services a covered person may receive from the in-network provider, such as a primary care physician or a specialist.

**Highlights of your plan**

Your Humana National Preferred Plan is a Preferred Provider Organization (PPO) plan insured by Humana Insurance Company. As a PPO, your Humana National Preferred Plan provides coverage for a wide range of services.

**Your benefits include:**

- Preventive care
- Physician services
- Hospital services
- Emergency services
- Ambulance services
- Durable medical equipment
- Home health services
- Hospice services
- Physical, occupational and speech therapy
- Skilled nursing facility services
- Urgent care
- Behavioral health services
- X-ray and laboratory
- Maternity services
- Transplants
- Prescription drugs

**Some plans may include:**

- Children’s vision care
- Children’s dental care

A brief description of the above listed benefits is provided below. This is not a complete list or description of all your benefits. For complete details about covered services, refer to your Certificate of Insurance. Prospective members can view a sample Certificate of Insurance on Humana.com.
**Preventive care**
Your plan includes coverage for preventive care, such as:

- A health risk assessment
- Routine physical exams
- Well-child care
- Necessary immunizations - it’s important for you and your family to get all your immunizations because they help the body fight disease. Children may need certain shots before they can start school. Your child’s physician will tell you when shots are required.
- An annual well-woman exam
- Prostate cancer detection exam

**Physician services**

- **Choosing or changing your physician**
  With the Humana National Preferred Plan, you have the freedom to use any in-network or out-of-network provider. Your out-of-pocket expenses will be lower by receiving care from an in-network healthcare provider. While you don’t need to have one healthcare practitioner to coordinate your care, it’s always a good idea to have one physician you trust and see for your healthcare needs. This person can get to know you and your medical history and give you health advice. Typically, this is a physician who is a family practitioner, pediatrician or who specializes in internal medicine. This provider can:
  
  - Provide most of your medical care
  - Keep your medical records
  - Guide you when you need special care

There is a “Find a doctor or pharmacy” tool on Humana.com and also on your personal MyHumana page that you can use to choose a physician in your plan’s network. You may also request a printed copy of a provider directory by calling Customer Care at 1-800-448-6262 (TTY: 711). The directory for your network includes service areas, by county or ZIP code, and listings of facilities and physicians along with their addresses and contact information. The directory is subject to change. Due to the possibility of in-network providers changing status, be sure to check the online directory of network providers or call Customer Care prior to obtaining services.

- **Visiting your physician**
  Whenever you need to see your physician, simply call the office and make an appointment. If you’re going to be late for an appointment, call the office and tell them. If you can’t keep an appointment, call the office as soon as possible to reschedule. Please try to give notice at least 24 hours in advance. That way, the physician can use the time to see other patients. You should make an appointment to meet your physician to review your general health. This gives your physician the chance to get to know you and your medical history. After your first visit, your physician may recommend a checkup or a routine appointment. Your physician may determine you need specialist services. With a Humana National Preferred Plan, you have the freedom to receive care from any in-network or out-of-network specialist. Your out-of-pocket expenses will be lower by using an in-network healthcare provider.
Specialized care
Your plan covers a wide range of specialized medical services. When you need specialized care, you’ll want to use the “Find a doctor or pharmacy” tool found on Humana.com and also on your personal MyHumana page to find a specialist in your plan’s network. You may also request a printed copy of a provider directory by calling Customer Care at 1-800-448-6262 (TTY: 711). The directory is subject to change. Due to the possibility of in-network providers changing status, be sure to check the online directory of network providers or call Customer Care before obtaining services. Remember - you have the freedom to receive care from any in-network or out-of-network specialist, but your out-of-pocket expenses will be lower by using an in-network healthcare provider.

Access to services after hours
If you have medical questions or concerns, you can call your physician’s office 24 hours a day, seven days a week. As a Humana member, your plan also includes HumanaFirst®, a 24-hour nurse advice line. You can call HumanaFirst® anytime, day or night. With HumanaFirst®, you’ll have access to a registered nurse who will help you assess your symptoms. Call the toll-free number on the back of your ID card or visit the online FAQ at Humana.com.

Outpatient care
Covered services of physicians and nurses are subject to the limitations and exclusions in your plan. Office visits, outpatient surgery, anesthesia, allergy treatment and materials, immunizations, hearing and vision screening exams and prosthetic devices are included in plan coverage. Many routine diagnostic lab tests and X-rays also are covered under the plan.

Network changes
To get the most from your health plan coverage, use providers in Humana’s provider network. Make sure the physician you select currently participates in the network and will accept new patients. Just go to Humana.com and under “Find a doctor or pharmacy,” click “search.” If you prefer, call Customer Care at the number on the back of your Humana member ID card.

Second opinion
If you want a second opinion about your care for any reason, you may see another healthcare provider of your choice.

Hospital services
If you need hospital care, you have the freedom to go to any hospital of your choice. However, your out-of-pocket expenses will be lower by going to an in-network healthcare facility. Additionally, your plan may require, as a condition of coverage, that certain medical conditions be treated at specific facilities.

Your Humana National Preferred Plan provides coverage for:
Inpatient care

- As many days as medically necessary, in a semiprivate room (private room when authorized by your physician due to medical necessity)
- Preadmission testing
- Medically necessary supplies and services
- Services from a healthcare provider, who directs your care while you’re in an inpatient facility

Outpatient care

- Outpatient surgery
- Outpatient diagnostic services
- Home health services

Chronic condition management

Humana offers phone-based support for members managing complex chronic conditions. Specially trained nurses reach out to those at risk or currently dealing with serious health issues. Members work with the same nurse every time – a nurse who takes the time to understand your unique situation. Nurses provide education specific to your health. They also provide guidance about benefits, as well as counseling before and after you go to the hospital. That helps you fully understand your health benefit options and choices. Chronic condition nurses help you navigate the healthcare system, work better with your physician and make smart health decisions with confidence.

Case management

Severe illness or injury can require many providers, hospitals and treatment programs. Humana’s Case Managers work with members to help ensure a successful recovery. Complex-Case Managers provide ongoing support to members with the most catastrophic needs. Nurses offer education and refer members to community resources to overcome hurdles. They support catastrophic conditions such as trauma, complex surgical cases, automobile accidents and severe burns. Case Managers also provide follow-up calls to members after they return home to assist in the transition. These programs focus on easing the physical and emotional burden associated with a major medical event.

Inpatient coordination of care

Concurrent review is the process that determines coverage during the length of stay in the hospital/acute rehab/skilled nursing facility.

Retrospective review

Humana or one of its contracted utilization review agents will conduct a retrospective review of inpatient services when prospective preadmission notification and other reviews aren’t obtained. When this occurs, the claim information for a nonauthorized inpatient stay is directed to the local market office for review by the Utilization Management department or to one of Humana’s contracted utilization review agents. If we deny services based on an adverse determination of medical necessity, you can appeal the decision. Please refer to the “Complaint & Appeals Procedures” section within this handbook.
Emergency services

What is an emergency?

Emergency care means services provided in a hospital emergency facility, freestanding emergency medical care facility or a comparable emergency facility to evaluate and stabilize medical conditions of a recent onset and severity for a bodily injury or sickness manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of that individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment of bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency care does not mean services for the convenience of the covered person or the provider of treatment or services.

What to do in an emergency

If you have a medical emergency, go to the nearest hospital emergency room (ER) or call 911 for help. You don't have to notify your physician before the ER visit. After receiving emergency care, it's a good idea to notify your physician and Humana within 48 hours, or as soon as possible. Call Humana at 1-800-448-6262. You may need follow-up care after the emergency when your condition has stabilized. Don't forget to inform your physician of your treatment and, should you seek follow-up care, consider using in-network providers to have lower out-of-pocket expenses.

Seeking emergency care

When seeking emergency care, you should do the following:

- If your medical condition permits, proceed to the nearest emergency care facility. You may use any hospital whether it's in-network or out-of-network. If possible, use an in-network facility to have lower out-of-pocket expenses.
- If you're admitted to an out-of-network hospital after emergency care, you may have higher out-of-pocket expenses.

For details about emergency coverage, refer to your Certificate of Insurance. The Certificate of Insurance has a list of all coverage and exclusions. After receiving emergency care, it's a good idea to notify your physician and Humana within 48 hours, or as soon as possible. Call Humana at 1-800-448-6262.

Out-of-area care

The service area is the area where the plan provides coverage. The Humana National Preferred Plan includes a broad national network of health care providers so that you and your eligible dependents are covered regardless of geographic location.
If you have medical questions or concerns, you can call the HumanaFirst® Nurse Advice Line at the toll-free number on the back of your ID card. You will talk to a registered nurse who can help you decide what to do.

Your Humana National Preferred Plan covers emergency care in and out of the service area. If you have an emergency, you should go to the nearest hospital ER, or call 911 for help. Humana will review all out-of-area care to determine if the care was medically necessary. If it is determined the situation is not a medical emergency, you may have to pay the bill.

**Ambulance services**
Ambulance service must be for emergency transportation to or from the nearest hospital or ambulatory surgical center qualified to treat a member’s sickness or injury.

**Durable medical equipment**
Durable medical equipment means equipment that meets all of the criteria as listed in your Certificate of Insurance. Most durable medical equipment is a covered benefit. Coverage may be provided for rental or purchase of durable medical equipment. If the cost of renting the equipment is more than its purchase price, only the cost of the purchase will be covered. However, certain items aren’t covered, including tub chairs, elastic supports and environmental control items. You may obtain the preauthorization list online at Humana.com or call the Customer Care department at 1-800-448-6262 to confirm coverage and authorization requirements.

**Home health services**
Humana’s Utilization Management department or our contracted utilization review agent, along with your physician, arranges:

- Home nursing care
- Medical social work
- Nutrition services
- Physical, occupational, respiratory and speech therapy

Your healthcare providers and Humana will help you to determine what home healthcare needs are medically necessary and covered under your plan. Nursing care must be by or under the supervision of a registered nurse or licensed practical nurse. Medically necessary appliances and equipment and laboratory services also may be covered. Review your Certificate of Insurance for applicable limitations of this benefit.

**Hospice services**
Inpatient and outpatient hospice services are a covered benefit. Refer to your Certificate of Insurance.

**Physical, occupational and speech therapy**
Your plan covers rehabilitative services including physical, occupational and speech therapies. Preauthorization may be required. Therapy is covered only if that treatment, in the judgment of
your physician, will significantly improve your condition. Review your Certificate of Insurance for applicable limitations of this benefit.

**Skilled nursing facility services**
For exact specifications and limitations on care in a skilled nursing facility, including physician visits during your stay, refer to your contract. Custodial care isn’t covered.

**Urgent care**
Sometimes you have a medical problem that’s not serious enough to be a medical emergency. If you have a sickness or bodily injury requiring medical attention, but it isn’t an emergency or a life-threatening situation, you may want to see your physician or an urgent care facility near you.

You also may contact the HumanaFirst® Nurse Advice Line to talk with a registered nurse who can help you assess your symptoms. Call the toll-free number on the back of your ID card.

**Behavioral health services**
Your plan covers services for inpatient and outpatient mental health, serious mental illness and chemical dependency services. Refer to your Certificate of Insurance.

**X-ray and laboratory**
Your plan covers:
- X-ray and laboratory tests
- Diagnostic procedures, tests or X-ray exams and treatments
- Radiation therapy
- Lab tests or analysis made for diagnosis or treatment
- Microscopic tests

Some imaging services may require preauthorization. Call the Customer Care number on the back of your Humana member ID card to verify.

**Maternity services**
Hospital room and board (semiprivate accommodation), services and supplies while confined in the hospital and physician care are covered under the plan. This includes cost and administration of anesthetics. Coverage also includes pre- and postnatal care and medically necessary testing in a physician’s office.

HumanaBeginnings® is dedicated to helping Humana members make healthy decisions throughout pregnancy. The program combines personal contact with a registered nurse and informative mailings.

Members can:
- Find out more about their pregnancy
- Follow their baby’s development
- Practice healthy habits along the way

If you’d like more information about HumanaBeginnings®, or if you’re a Humana member who’s expecting a baby, call us toll-free at 1-888-847-9960. To enroll online, Humana
members can sign in to MyHumana and select “Health & Wellness.” You also may contact the HumanaFirst® Nurse Advice Line to talk with a registered nurse. Call the toll-free number on the back of your ID card.

**Transplants**

You or your physician must call the Humana National Transplant Network at 1-866-421-5663 as soon as you, or a covered dependent make the decision to proceed with a covered transplant. The Humana Transplant Management department will provide assistance and coordinate all your covered transplant services with a Humana National Transplant Network facility. This will maximize the benefits of your health plan. Review your Certificate of Insurance for applicable limitations of this benefit.

**Prescription drugs**

To have a prescription filled, simply go to any participating pharmacy and show your Humana member ID card. You are required to pay a copayment or a portion of the drug cost for each prescription based on the assigned level of the drug as specified on the drug list. You can obtain a copy of the drug list at Humana.com or call Customer Care at the number on the back of your Humana member ID card. Information on the drug list may change at the renewal of the group plan. We will provide written notice no later than 60 days prior to the effective date of the change.

Descriptions of the various prescription drug benefits are provided below. To determine which prescription drug benefit is applicable to your plan, please review the plan materials provided to you, including your Certificate of Insurance to view specific prescription drug benefits, including your cost-share, coverage description, and any limitations and exclusions. As a member, you can also visit Humana.com and sign in to MyHumana to view your cost-share for prescription drug benefits.

- **Rx3 Prescription Drug Benefit**
  Covered prescription drugs are assigned to one of three different levels with corresponding copayment or coinsurance amounts; specialty drugs are also indicated. The levels are organized as follows:
  - **Level One:** Includes low-cost generic drugs.
  - **Level Two:** Includes preferred brand-name drugs. Includes lower-cost brand drugs.
  - **Level Three:** Includes higher-cost brand-name drugs.
  - **Specialty Drugs:** High-cost/high-technology drugs that often require special dispensing conditions.

- **Rx4 Prescription Drug Benefit**
  Covered prescription drugs are assigned to one of four different levels with corresponding copayment or coinsurance amounts; specialty drugs are also indicated. The levels are organized as follows:
  - **Level One:** Includes low-cost generic and brand-name drugs.
  - **Level Two:** Includes higher-cost generic and brand-name drugs.
  - **Level Three:** Includes high-cost, mostly brand-name drugs. These drugs may have generic or brand-name alternatives in levels One or Two.
  - **Level Four:** Includes highest-cost drugs.
Specialty Drugs: High-cost/high-technology drugs that often require special dispensing conditions.

- **Rx5 Prescription Drug Benefit**
  
  Covered prescription drugs are assigned to one of five different levels with corresponding copayment or coinsurance amounts. The levels are organized as follows:
  
  **Level One:** Includes preferred, low-cost generic drugs.
  
  **Level Two:** Includes low-cost generic drugs.
  
  **Level Three:** Includes higher-cost generic and preferred brand name drugs.
  
  **Level Four:** Includes non-preferred brand name and higher-cost generic drugs. These are higher-cost brand drugs, often with a preferred generic alternative.
  
  **Level Five:** Includes covered specialty drugs – primarily drugs that must be self-administered.

**Dispense as Written:** If you request a brand-name drug when an equivalent generic drug is available, your cost is greater. You are responsible for the applicable brand-name drug copayment or coinsurance amount, plus 100% of the cost difference between the brand-name drug and generic drug. If your prescribing physician indicates that a generic drug cannot be substituted by writing “Dispense as Written” on your prescription, you can only receive that specific drug, even if a generic equivalent is available. As a result, you will be charged the applicable brand-name copayment or coinsurance amount. In this case, you will not be responsible for the cost difference between the brand-name drug and generic drug. If you discover at the pharmacy that your physician gave you a “Dispense as Written” prescription, you can ask the pharmacist to contact your physician for approval of a generic equivalent.

**Children’s vision care**

Some Humana National Preferred Plans include children’s vision care. If covered, your physician will refer your child, if necessary, for medical diagnosis. Please see the specific plan documents, including your Certificate of Insurance to see if this is included in your plan and for more information on this benefit.

**Children’s dental care**

Some Humana National Preferred Plans include children’s dental care. Please see the specific plan documents, including your Certificate of Insurance, to see if this is included in your plan and for more information on this benefit. To find a dentist near you, visit [Humana.com](http://Humana.com).

This is not a complete list or description of all your benefits. Not all services or supplies your physician may order or suggest are covered benefits under your plan. This is the case even when your physician refers you to other in-network providers for services. For complete details about covered services, refer to your Certificate of Insurance. Prospective members can view a sample Certificate of Insurance on [Humana.com](http://Humana.com).
Facility-based physician disclosure

Healthcare services may be or have been provided to you at a healthcare facility that is a member of our provider network, other professional services may be or have been provided at or through the facility by physicians and other healthcare practitioners who are not members of our network. You may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by us. If you receive a bill, you should contact us by calling the Customer Care number on the back of your Humana member ID card.

Your financial responsibilities

Covered services

To receive covered benefits, you must pay the premium by the due date. You are responsible to pay any deductible, coinsurance and copayment to a provider for covered services you receive. Plan specific deductibles, coinsurance and copayments are provided in the Summary of Benefits and Coverage (SBC) for prospective members and on the Schedule of Benefits in the members' Certificate of Insurance. Prospective members can obtain the SBC from the benefits coordinator of the employer or insurance agent. Members can view their plan specific Certificate of Insurance by accessing MyHumana on Humana.com.

When you select a healthcare provider from your approved network, the in-network provider has agreed to accept discounted or negotiated fees for covered services and will not bill you for charges in excess of the negotiated fees. You are only responsible to pay an in-network provider any deductible, coinsurance and copayment for covered services received. However, if you receive covered services from an out-of-network provider, the provider may bill you for amounts in addition to any applicable deductible, coinsurance or copayment. With a National Preferred Plan, you can receive care from any in-network or out-of-network provider. Your out-of-pocket expenses will be lower by using in-network providers.

Non-covered services

If you obtain non-covered health services, whether from an in-network provider or an out-of-network provider, you’re responsible for making the full payment to the healthcare provider.

Limitations and exclusions

Unless specifically stated otherwise, no benefits will be provided for or on account of the following items:

- Treatments, services, supplies or surgeries that are not medically necessary, except for preventive services.
- A sickness or bodily injury that is covered under any Workers’ Compensation or similar law. This limitation also applies to a covered person who is not covered by Workers’ Compensation and lawfully chose not to be.
- Care and treatment given in a hospital owned or run by any government entity, unless you are legally required to pay for such care and treatment. However, care and treatment provided by military hospitals to covered persons who are armed services retirees and their dependents are not excluded.
• Any service you get while you are confined in a hospital or institution owned or operated by the United States government or any of its agencies for any military service-connected sickness or bodily injury.
• Any service you would not be legally required to pay for if you did not have this insurance.
• Sickness or bodily injury for which you are paid or entitled to payment or care and treatment by or through a government program.
• Any service not ordered by a healthcare practitioner.
• Any drug, biological product, device, medical treatment or procedure which is experimental or investigational or for research purposes except for clinical trials.
• Legend drugs, which are not deemed medically necessary by Humana.
• Prescription drugs not included on the drug list.
• Drugs not approved by the FDA.
• Any drug prescribed for intended use other than for indications approved by the FDA or off-label indications recognized through peer-reviewed medical literature.
• Any drug prescribed by a sickness or bodily injury not covered under the plan.
• Any drug, medicine or medication that is either labeled "Caution-limited by federal law to investigational use" or experimental, investigational or for research purposes, even though a charge is made to you.
• Any prescription fill or refill for drugs, medicines or medications that are lost stolen, spoiled, spoiled or damaged.

This is not a complete list of all the Limitations and Exclusions applied to benefits covered by the plan. For a complete listing, refer to your Certificate of Insurance. Prospective members can view a sample Certificate of Insurance on Humana.com.

Preauthorization requirements

Humana requires preauthorization for some services and procedures your physician or healthcare provider may recommend for you. Preauthorization (also referred to as prior authorization) means that you or your healthcare provider contact Humana before you receive services. Humana does this to determine whether the service or procedure qualifies for payment under your benefit plan. You and your healthcare provider decide whether you should have the services or procedures. Humana's preauthorization determination relates to payment by Humana. Failure to obtain necessary preauthorization when required may result in a reduction of benefits for those services or supplies. Please call the Customer Care number on the back of your ID card or visit Humana.com to receive a list of services that require preauthorization. The list is updated periodically and subject to change.

Preauthorization for emergency services is not required.

Investigational and experimental procedures are not usually covered benefits. Be sure to contact Humana if you're considering care that involves experimental procedures.

Based on regulatory requirements and your Certificate of Insurance, physicians and other clinical associates determine if Humana covers a service.

If a service doesn’t meet the guidelines on initial review, the case is referred to a Humana medical director. The provider gets an opportunity to discuss the plan of treatment and medical guidelines for the decision. This happens before we issue an adverse determination or suggested alternative. The provider can appeal an adverse coverage determination.
Utilization management

The Humana call center or a utilization review agent contracted with Humana manages calls from healthcare providers to fulfill the requirements of notification and preauthorization of members’ inpatient admissions. Certain procedure or durable medical equipment (DME) requests may require review to determine coverage. This depends on network utilization and plan determination.

Humana contracts with various utilization review companies (utilization review agents) to assist with preauthorizations or retrospective reviews. If you have questions or concerns or wish to contact the utilization review agent conducting your review you may contact Humana at 1-800-448-6262 to obtain information on how to contact either the Utilization Review Department at Humana or the agent assigned by Humana to conduct your specific utilization review or preauthorization.

You also can find an updated preauthorization list on Humana.com. Click on “Insurance through an employer” at the top of the home page. Then click on “Rx Tools.” Scroll down to and click on “Authorization and Referrals” Scroll down to “Getting your medications approved” to view the preauthorization document. (Note: This form can be used for medical services and prescription drugs.) You also can call us with any questions by dialing the number on the back of your Humana member ID card.

Continuity of care

In the event a covered person is under the care of an in-network provider at the time a provider’s participation in the network terminates, for reasons other than medical competence or professional behavior, the covered person may continue treatment with the terminating provider if the covered person has a special circumstance in accordance with the dictates of medical prudence such as:

- A disability;
- An acute condition;
- Being treated for a life threatening or complex illness; or
- Is past the twenty-fourth week of pregnancy.

Special circumstance means a condition a treating healthcare practitioner or provider reasonably believes that discontinuing care by the healthcare practitioner or provider could cause harm to the covered person. Special circumstances are identified by the treating healthcare practitioner or provider. The treating healthcare practitioner or provider must:

- Contact us requesting the covered person be permitted to continue treatment under the healthcare practitioner or provider’s care, and
- Agree not to seek payment from the covered person for any amount the covered person would not be responsible to pay if the healthcare practitioner or provider were still an in-network provider.
- If we agree to the continued treatment, medically necessary services provided to the covered person by the terminating healthcare practitioner or provider will continue to be payable at the in-network provider benefit level.
• The maximum duration of continued treatment under this provision may not exceed:
  o 90 days from the effective date of termination of the provider’s agreement;
  o Nine months from the effective date of termination of the provider’s agreement in the case of a covered person diagnosed with a terminal illness; or
  o Through the delivery of a child, including immediate post-partum care and follow-up visit within the first six weeks of delivery in the case of a covered person past the twenty-fourth week of pregnancy.

Member services

Open enrollment
Employers usually set aside time for changing from one healthcare plan to another or for making changes in coverage. At other times, changes in your enrollment can generally be made if:

• You lose your group health plan coverage
• Your family size changes due to marriage, divorce or birth or adoption of a child

Enrollment changes for these reasons must generally be made within 31 days of the event. Check with your employer for group-specific provisions.

Dependent coverage
Eligible dependents generally include your spouse and children up to a specified age. Check your Certificate of Insurance for more information, including specific coverage.

Loss of coverage
Humana can remove you from the Humana National Preferred Plan if you:

• Fail to pay plan premiums
• Commit fraud or make an intentional misrepresentation of a material fact

Your Humana member ID card
You’ll be issued a Humana member ID card to show that you’re a member of the plan. Be sure to carry it with you at all times. You'll need to present the card anytime you receive medical care. If your Humana member ID card is lost or damaged, you can get a new one on MyHumana, or you can call Customer Care. We'll send you a replacement card.

Effective date of coverage
Your effective date of coverage, and when you’re first eligible to receive plan benefits, is determined by your employer. Ask your personnel office or benefits administrator for information about your effective date.

Plan status change
If you have individual coverage with your employer and want to change to the family plan, you must notify your employer of the new change within the number of days specified in your Certificate of Insurance. Please see your employer about changes in coverage.
**Keep us up to date**
Please notify our Customer Care team whenever there's a change in your name, address or telephone number.

**Customer Care**
If you have comments on our service or ideas on how we can improve, please call **1-800-448-6262** (TTY: 711), 8 a.m. – 6 p.m., Monday – Friday.

**Plan provisions**

**Continuation of benefits**
If your group coverage ends, you may be allowed to continue coverage through your employer. Ask your company's benefits administrator or refer to your Certificate of Insurance.

**Coordination of benefits**
If you or your family members are covered by more than one healthcare plan, you can't collect full benefits from both plans. In this case, Humana will work with the other plan to decide which plan will have primary responsibility for paying for your medical care. To help us do this, we may ask you for information about other coverage you may have.

Remember that each healthcare plan may require you to follow certain rules or use specific physicians and hospitals. It may be impossible to comply with both plans at the same time. Be sure to read and understand the rules for any healthcare plan that covers you or your family.

**Filing a claim**
In-network providers will submit claims to us on your behalf. If you receive covered services from an out-of-network provider, you may be asked to pay the out-of-network provider directly and submit a notice of claim to Humana. In that case, you should obtain a receipt, an itemized statement and any medical records associated with your care. The forms necessary for filing these claims are available on [Humana.com](http://Humana.com).

Submit copies of these to the Humana Claims department at:
Humana Insurance Company
Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Within 15 business days of receiving satisfactory proof-of-loss, we will provide you with written notice of our decision to accept or reject a claim or provide reasons why additional time is needed to make a decision. A decision will be made within 45 days of the date of our letter. If the claim is accepted, it will be paid in whole or part within five days of the written approval notice you receive.

If your claim is denied and you aren’t reimbursed, you may ask to have the claim reviewed. If you have any questions about the review procedure, call our Customer Care team.
Your rights and responsibilities
As a Humana member, you have certain rights and responsibilities.

You have the right to:

- Be provided with information about your Humana National Preferred Plan, its services and benefits, its providers and your member rights and responsibilities.
- Choose either in-network or out-of-network healthcare providers. Your out-of-pocket expenses will be lower by using the services of in-network providers.
- Privacy and confidentiality regarding your medical care and records. Records pertaining to your healthcare will not be released without your, or your authorized representative’s, written permission, except as permitted or required by law.
- Discuss your medical record with your physician and receive, upon request, a summary copy of that record.
- Be informed of your diagnosis, treatment choices — including non-treatment — and prognosis in terms you can reasonably expect to understand and to participate in decision-making about your healthcare and treatment plan.
- Have a candid discussion with your physician about appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Expect reasonable access to medically necessary healthcare services regardless of race, national origin, religion, physical abilities or source of payment.
- File a formal complaint, as outlined in the plan’s appeal procedure, and to expect a response to that complaint within a reasonable period of time.
- Be treated with courtesy and respect with appreciation for your dignity and protection of your right to privacy.
- Participate in wellness programs.
- Receive assistance from Humana’s Customer Care specialists to address your concerns and questions.

It’s your responsibility to:

- Give Humana and your healthcare provider complete and accurate information as needed to arrange care for you.
- Read and be aware of all material distributed by Humana about the plan explaining policies and procedures regarding services and benefits.
- Obtain and carefully consider all information you may need or desire to give informed consent for a procedure or treatment.
- Follow the treatment plan agreed on with your healthcare provider and to weigh the potential consequences of any refusal to observe those instructions or recommendations.
- Be considerate and cooperative in dealing with the plan providers and to respect the rights of other plan members.
- Schedule appointments, arrive on time for scheduled visits and notify your healthcare provider if you must cancel or be late for a scheduled appointment.
- Express opinions, concerns or complaints in a constructive manner.
- Tell us in writing if you move or change your address or phone number, even if these changes are only temporary.
- Pay all copayments and/or premiums by the date when they are due.
• Be honest and open with your physician and report unexpected changes in your condition in a timely fashion.
• Follow healthcare facility rules and regulations affecting patient care and conduct.
• Carry your Humana member ID card with you at all times and use it while enrolled in the Humana National Preferred Plan.

Complaint & Appeals Procedures

If you have a complaint

We want you to be happy with your Humana National Preferred Plan. If you aren’t satisfied with the healthcare or services you receive, please call Customer Care and tell us. The Customer Care phone number is on your member ID card.

If you’re not satisfied with the results of your call, you can file a formal complaint by writing to:

Humana Insurance Company
Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546

Please refer to the information below when filing a formal complaint.

Complaint procedures

“Complaint” means any dissatisfaction you express — orally or in writing — to us about any aspect of our operation. This includes, but isn’t limited to:

• Dissatisfaction with plan administration
• How we provide a service
• Disenrollment decisions
• Procedures related to the review or appeal of an adverse determination
• Procedures related to the denial, reduction or termination of a service for reasons not related to medical necessity

A complaint isn’t a misunderstanding or a problem of misinformation that’s resolved by supplying appropriate information to your satisfaction. It also doesn’t include adverse determinations.

If you notify us of a complaint, within five business days of the receipt of the complaint we will send you a letter acknowledging the date we received the complaint. The letter will include Humana’s complaint procedures and time frames for resolution.

If the complaint was received by phone, we will send you a one-page complaint form clearly stating the form must be returned to us for prompt resolution of the complaint. After receipt of the written complaint or one-page complaint form from you, we will investigate and send you a letter with our resolution within 30 days of our receipt of the complaint.

If the complaint is not resolved to your satisfaction, you have the right to appear in person or address a written appeal to a complaint appeal panel. Notice of our final decision will be provided within 30 calendar days from receipt of the request for a complaint appeal panel.
**Internal appeal of adverse determination**

“Adverse determination” means a determination by Humana or a utilization review agent that the healthcare services provided or proposed to be provided to a member are not medically necessary or are not appropriate, or are experimental or investigational. Adverse determination does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

The member, anyone acting on the member’s behalf or provider has the right to appeal an adverse determination relating to medical necessity for denial of a service.

When we receive an appeal, we will, within five business days from the receipt of the appeal, send a letter to the appealing party acknowledging the date of our receipt of the appeal. This letter will include the appeal procedures and the time frames required for resolution. If an appeal of an adverse determination is received verbally, a one-page appeal form will be included with an acknowledgment letter to the appealing party.

After review of the appeal of the adverse determination, we’ll issue a response letter to the member — or a person acting on behalf of the member — and the member’s physician or healthcare provider.

This letter will explain the resolution of the appeal as soon as is practical. This will take place before the 30th calendar day from when we receive the appeal.

If the appeal is for emergency care, denial of a continued stay for hospitalized patients, or denial of prescriptions drugs or intravenous infusions, we’ll base the time frame for resolution on the medical or dental immediacy of the condition, procedure or treatment. This won’t exceed one working day from the date we receive all information necessary to complete the appeal. The resolution letter will contain the clinical basis for the appeal’s denial, the specialty of the health care practitioner making the denial, and notice of the claimant’s right to seek review of the denial by an Independent Review Organization.

**Filing complaints with the Texas Department of Insurance**

Any person, including persons who have attempted to resolve complaints through our complaint and appeal process and who aren’t satisfied with the resolution, can report an alleged violation to:

Texas Department of Insurance
Consumer Protection Section
Mail Code: 111-1A
PO Box 149091
Austin, TX 78714-9091
ConsumerProtection@tdi.texas.gov

The Texas Department of Insurance will investigate a complaint against us to determine compliance. This will happen within 60 days of the Texas Department of Insurance’s receipt of the complaint and all information necessary for the department to determine compliance. The commissioner may extend the time necessary to complete an investigation if:

- Additional information is necessary
- We, the provider or the member doesn’t provide all documentation necessary to complete the investigation
- An on-site review is necessary
- Other circumstances beyond the control of the department occur
**External appeal to Independent Review Organization (IRO)**

An Independent Review Organization (IRO) process is available to you. Refer to your Certificate of Insurance for the IRO process.

**Right to bring a civil action**

You can file a civil action under Section 502 (a) of the Employee Retirement Security Act (ERISA) if all the following apply:

- Your plan is governed by ERISA
- You have exhausted your ERISA appeal rights
- Your claim was not approved on appeal

Humana is prohibited from retaliating against a member or group contract holder because the member or group contract holder has filed a complaint against Humana or appealed a decision of Humana, and is prohibited from retaliation against a physician or provider because of a member, reasonably filed a complaint against Humana or appealed a decision of Humana.

**Network Information**

**Provider lists**

A current list of network providers, including behavioral health and substance abuse providers can be found online at [Humana.com](https://www.humana.com). You also may request a printed copy by calling Customer Care at 1-800-448-6262. We offer many healthcare plans. A provider that is an in-network provider for one plan may not be an in-network provider for your plan. It is important for you to ensure the provider list is specific for the provider network listed on your ID card. The provider list includes names, locations and contact information for all physicians and providers in your network and whether new patients are being accepted. Please note, the network provider list is subject to change and is updated at least on a quarterly basis. Due to the possibility of in-network providers changing status, be sure to check the online directory of network providers or call Customer Care prior to obtaining services.

**For female enrollees**

**Right to designate an obstetrician or gynecologist**

(This notice is being provided to advise the member of rights under the Insurance Code Chapter 1451 Subchapter F.) You have direct access to receive gynecological and obstetrical care from an in-network or out-of-network obstetrician or gynecologist (OB/GYN), but your out-of-pocket expenses will be lower by using an in-network provider.

**Notice of rights**

- You have the right to an adequate network of preferred providers (also known as “network providers”). If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

- You have the right, in most cases, to obtain estimates in advance:
  - From out-of-network providers of what they will charge for their services; and
  - From your insurer of what it will pay for the services.
• You may obtain a current directory of preferred providers at the following website www.humana.com or by calling our toll free customer service number listed on your ID card for assistance in finding available preferred providers.

• If you are treated by a provider or facility that is not a preferred provider, you may be billed for anything not paid by the insurer.

• If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist or assistant surgeon, including the amount unpaid by the administrator or insurer, is greater than $500 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.

• If directory information is materially inaccurate and you rely on it, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

**Service area**
Because you are a member of a PPO, you are not required to use an in-network provider for healthcare services, but you may save money by using an in-network provider. Your in-network physicians are members of the Humana National Preferred Network. The network has providers in every county of each Texas geographic region.

Your network service area is the entire state of Texas:
TEXAS GEOGRAPHIC REGIONS
Region 1—Panhandle, including Amarillo and Lubbock.
Region 2—Northwest Texas, including Wichita Falls and Abilene.
Region 3—Metroplex, including Fort Worth and Dallas.
Region 4—Northeast Texas, including Tyler.
Region 5—Southeast Texas, including Beaumont.
Region 6—Gulf Coast, including Houston and Huntsville.
Region 7—Central Texas, including Austin and Waco.
Region 8—South Central Texas, including San Antonio.
Region 9—West Texas, including Midland, Odessa, and San Angelo.
Region 10—Far West Texas, including El Paso.
Region 11—Rio Grande Valley, including Brownsville, Corpus Christi, and Laredo.

NETWORK DEMOGRAPHIC INFORMATION

Number of insureds by geographic region

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<tr>
<td>Region 11</td>
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</tr>
</tbody>
</table>

Number of preferred providers for the following areas of practice by geographic region

**Region 1:**
- Internal medicine practitioners: 135
- Family/General practitioners: 307
- Pediatricians: 136 Refer to access plan
- Obstetricians and Gynecologists: 113 Refer to access plan
- Anesthesiologists: 338 Refer to access plan
- Psychiatrists: 6 Refer to access plan
- General Surgeons: 103 Refer to access plan

**Region 2:**
- Internal medicine practitioners: 58
- Family/General practitioners: 188
- Pediatricians: 38 Refer to access plan
- Obstetricians and Gynecologists: 35 Refer to access plan
- Anesthesiologists: 118 Refer to access plan
- Psychiatrists: 14 Refer to access plan
- General Surgeons: 39

**Region 3:**
- Internal medicine practitioners: 1143
- Family/General practitioners: 1802
- Pediatricians: 1180
- Obstetricians and Gynecologists: 1149
- Anesthesiologists: 1747 Refer to access plan
- Psychiatrists: 163 Refer to access plan
- General Surgeons: 737
Region 4:  
- Internal medicine practitioners: 169  
- Family/General practitioners: 402  
- Pediatricians: 117  
- Obstetricians and Gynecologists: 151  
- Anesthesiologists: 483  Refer to access plan  
- Psychiatrists: 30  Refer to access plan  
- General Surgeons: 97  

Region 5:  
- Internal medicine practitioners: 79  
- Family/General practitioners: 169  
- Pediatricians: 36  Refer to access plan  
- Obstetricians and Gynecologists: 46  
- Anesthesiologists: 46  Refer to access plan  
- Psychiatrists: 26  Refer to access plan  
- General Surgeons: 35  

Region 6:  
- Internal medicine practitioners: 1059  
- Family/General practitioners: 1658  
- Pediatricians: 1304  
- Obstetricians and Gynecologists: 1240  
- Anesthesiologists: 1513  Refer to access plan  
- Psychiatrists: 268  Refer to access plan  
- General Surgeons: 621  

Region 7:  
- Internal medicine practitioners: 445  
- Family/General practitioners: 1163  
- Pediatricians: 606  Refer to access plan  
- Obstetricians and Gynecologists: 503  
- Anesthesiologists: 1292  Refer to access plan  
- Psychiatrists: 166  Refer to access plan  
- General Surgeons: 302  

Region 8:  
- Internal medicine practitioners: 304  
- Family/General practitioners: 724  
- Pediatricians: 418  Refer to access plan  
- Obstetricians and Gynecologists: 456  
- Anesthesiologists: 789  Refer to access plan  
- Psychiatrists: 191  Refer to access plan  
- General Surgeons: 350  Refer to access plan  

Region 9:  
- Internal medicine practitioners: 91  
- Family/General practitioners: 157  
- Pediatricians: 67  Refer to access plan  
- Obstetricians and Gynecologists: 82  Refer to access plan  
- Anesthesiologists: 100  Refer to access plan  
- Psychiatrists: 2  Refer to access plan  
- General Surgeons: 48  Refer to access plan  

TXHHTCPEN 0818
Region 10:  
Internal medicine practitioners: 140
Family/General practitioners: 169
Pediatricians: 126  Refer to access plan
Obstetricians and Gynecologists: 134  Refer to access plan
Anesthesiologists: 604  Refer to access plan
Psychiatrists: 90
General Surgeons: 51  Refer to access plan

Region 11:  
Internal medicine practitioners: 218  Refer to access plan
Family/General practitioners: 434  Refer to access plan
Pediatricians: 379  Refer to access plan
Obstetricians and Gynecologists: 228
Anesthesiologists: 603  Refer to access plan
Psychiatrists: 35  Refer to access plan
General Surgeons: 135

When "Refer to access plan" is specified, the access plan for a region can be viewed on our website at Humana.com or obtained by calling Customer Service.

**Number of preferred provider hospitals by geographic region**

Region 1:  36
Region 2:  19
Region 3:  99
Region 4:  16  Refer to access plan
Region 5:  16
Region 6:  72
Region 7:  53
Region 8:  52  Refer to access plan
Region 9:  16  Refer to access plan
Region 10:  10  Refer to access plan
Region 11:  28  Refer to access plan

When "Refer to access plan" is specified, the access plan for a region can be viewed on our website at Humana.com or obtained by calling Customer Service.

**NETWORK WAIVERS OR LOCAL MARKET ACCESS PLANS**

Humana does not have waivers or local market access plans for its PPO network.
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, marital status, or religion. 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 1-866-427-7478 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,
- 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. 1-866-427-7478 (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.

Language assistance services, free of charge, are available to you. 1-866-427-7478 (TTY: 711)

**Español (Spanish):** Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

**繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。

**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika hanggang balat ng kayaad.

**Русский (Russian):** Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

**Français (French):**Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

**Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, gratuitos.

**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

**العربية (Arabic):** الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك.