Humana.

Annual Notice of Changes for 2018

You are currently enrolled as a member of Humana Medicare Employer PPO. Next year, there will be some changes to the plan's costs and benefits. This booklet tells about the changes.

What to do now

1. ASK: Which changes apply to you

- Check the changes to our benefits and costs to see if they affect you.
  - It's important to review your coverage now to make sure it will meet your needs next year.
  - Do the changes affect the services you use?
  - Look in Section 1 for information about benefit and cost changes for our plan.
- Check the changes in the booklet to our prescription drug coverage to see if they affect you.
  - Will your drugs be covered?
  - Are your drugs in a different tier, with different cost-sharing?
  - Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
  - Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
  - Look in Section 1.6 for information about changes to our drug coverage.
  - Review the 2018 *Drug Guide*. (See Chapter 6, Section 1.1 of the *Evidence of Coverage* for how to access the *Drug Guide*.)
- Check to see if your doctors and other providers will be in our network next year.
  - Are your doctors in our network?
  - What about the hospitals or other providers you use?
  - Look in Section 1.3 for information about our Provider Directory.
- Think about your overall health care costs.
  - How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
  - How much will you spend on your premium and deductibles?
  - How do your total plan costs compare to other Medicare coverage options?
- Think about whether you are happy with our plan.

2. CHOOSE: Decide whether you want to change your plan

- If you want to keep the Humana Medicare Employer PPO, you don't need to do anything. You will stay in the Humana Medicare Employer PPO.
- To change to a different plan that may better meet your needs, contact the benefit administrator at your former employer or union to obtain information on how to switch plans.

3. ENROLL: To change plans, contact the benefit administrator at your former employer or union to obtain information on how to switch plans.

- If you don’t join, you will stay in the Humana Medicare Employer PPO.
- If you join, your new coverage will begin with the start of the new plan year.

Additional Resources

- This information is available for free in other languages. Please contact Customer Care at the phone number located in Chapter 2, Section 1 of the *Evidence of Coverage* (EOC) for additional information. (TTY users should call 711.) Hours are from 8 a.m. to 9 p.m., Eastern time, Monday through Friday. Customer Care also has free language interpreter services available for non-English speakers.

- This information is available in a different format, including Braille, large print, and audio tapes. Please call Customer Care at the phone number located in Chapter 2, Section 1 of the *Evidence of Coverage* if you need plan information in another format.

- Minimum essential coverage (MEC): Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at **https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information on the individual requirement for MEC.

About Humana Medicare Employer PPO

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

- When this booklet says "we," "us," or "our," it means Humana Insurance Company, Humana Insurance Company of New York, Humana Insurance of Puerto Rico, Inc., and Humana Benefit Plan of Illinois, Inc. When it says "plan" or "our plan," it means Humana Medicare Employer PPO.

Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for Humana Medicare Employer PPO in several important areas. **Please note this is only a summary. It is important to read the rest of this Annual Notice of Changes** and review the attached *Evidence of Coverage* to see if other benefit or cost changes affect you.

PEIA Plan 1

Cost	2017 (this year)		2018 (next year)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Yearly deductible	$100.00	$100.00 combined in and out-of-network	$150.00	$150.00 combined in and out-of-network
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$850.00	$850.00 combined in and out-of-network	$1350.00	$1350.00 combined in and out-of-network
Doctor office visits	Primary care visits: $20 per visit	Primary care visits: $20 per visit	Primary care visits: $20 per visit	Primary care visits: $20 per visit
	Specialist visits: $40 per visit	Specialist visits: $40 per visit	Specialist visits: $40 per visit	Specialist visits: $40 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	$100 copayment per admission	$100 copayment per admission	$100 copayment per admission	$100 copayment per admission

PEIA Retiree Assistance Program

Cost	2017 (this year)		2018 (next year)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Yearly deductible	$25.00	$25.00 combined in and out-of-network	$50.00	$50.00 combined in and out-of-network
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$325.00	$325.00 combined in and out-of-network	$650.00	$650.00 combined in and out-of-network
Doctor office visits	Primary care visits: $2 per visit	Primary care visits: $2 per visit	Primary care visits: $2 per visit	Primary care visits: $2 per visit
	Specialist visits: $5 per visit	Specialist visits: $5 per visit	Specialist visits: $5 per visit	Specialist visits: $5 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	$100 copayment per admission	$100 copayment per admission	$100 copayment per admission	$100 copayment per admission

You may be receiving a subsidy from your former employer or union to pay for some or all of your plan's premium. Please contact your former employer or union's group benefit plan administrator for information about your plan premium. (See Chapter 1, Section 4.1 of the *Evidence of Coverage* for more information.)

Annual Notice of Changes for 2018

Table of Contents

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 Changes to the Monthly Premium

You may be receiving a subsidy from your former employer or union to pay for some or all of your plan's premium. Please contact your former employer or union's group benefit plan administrator for information about your plan premium. (See Chapter 1, Section 4.1 of the *Evidence of Coverage* for more information.)

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as “creditable coverage”) for 63 days or more, if you enroll in Medicare prescription drug coverage in the future.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving "Extra Help" with your prescription drug costs.

Section 1.2 Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. These limits are called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

PEIA Plan 1

Cost	2017 (this year)	2018 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$850.00	$1350.00 Once you have paid $1350.00 out-of-pocket for covered Part A and Part B services from network providers, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$850.00	$1350.00 Once you have paid $1350.00 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.

PEIA Retiree Assistance Program

The PEIA retiree assistance program offers retirees the opportunity for decreased premiums as well as modifications to their benefits. If PEIA determines you qualify for this assistance, please refer to the chart below for your modified benefit information. For more information regarding qualifications, please contact PEIA.

PEIA Retiree Assistance Program

Cost	2017 (this year)	2018 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$325.00	$650.00 Once you have paid $650.00 out-of-pocket for covered Part A and Part B services from network providers, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$325.00	$650.00 Once you have paid $650.00 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.

Section 1.3 Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at **Humana.com**. You may also call Customer Care (phone numbers are located in Chapter 2, Section 1 of the *Evidence of Coverage*) for updated provider information or to ask us to mail you a Provider Directory. **We strongly suggest that you review our current Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are still in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year.

An updated Provider Directory is located on our website at **Humana.com**. You may also call Customer Care (phone numbers are located in Chapter 2, Section 1 of the *Evidence of Coverage*) for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2018 Provider Directory to see which pharmacies are in our network.**

Section 1.5 Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, Medical Benefits Chart (what is covered and what you pay), in your 201*8 Evidence of Coverage.*

PEIA Plan 1

	2017 (this year)	2018 (next year)
Diabetic Eye Exam		
All Places of Treatment- IN	$40 copay	$0 copay
All Places of Treatment- OON	$40 copay	$0 copay
Web/Phone Based Technologies	Web/Phone Based Technologies - Not available	$20 copayment for web/phone based technology up to unlimited per year. Web/Phone Based Technologies - Available in all states except Arkansas and Idaho. Web Based Technologies only - Available in Arkansas and Idaho.

PEIA Retiree Assistance Program

	2017 (this year)	2018 (next year)
Diabetic Eye Exam		
All Places of Treatment- IN	$5 copay	$0 copay
All Places of Treatment- OON	$5 copay	$0 copay
Web/Phone Based Technologies	Web/Phone Based Technologies - Not available	$2 copayment for web/phone based technology up to unlimited per year. Web/Phone Based Technologies - Available in all states except Arkansas and Idaho. Web Based Technologies only - Available in Arkansas and Idaho.

Section 1.6 Changes to Part D Prescription Drug Coverage

Changes to Our Drug Guide

Our list of covered drugs is called a Formulary or "Drug Guide." You can view the most complete and current *Drug Guide* information by visiting our website at **Humana. com**. (See Chapter 6, Section 1.1 of the *Evidence of Coverage* for how to access the *Drug Guide*.) You can also call Customer Care to find out if a particular drug is in the plan's *Drug Guide* or to ask for a copy of the latest version of the *Drug Guide*. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of the *Evidence of Coverage*.)

We made changes to our Drug Guide, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug Guide to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception to cover the drug**.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) or call Customer Care (phone numbers are located in Chapter 2, Section 1 of the *Evidence of Coverage*).
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Care (phone numbers are located in Chapter 2, Section 1 of the *Evidence of Coverage*) to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Meanwhile, you and your doctor will need to decide what to do before your temporary supply of the drug runs out.

- **Perhaps you can find a different drug** covered by the plan that might work just as well for you. You can call Customer Care (phone numbers are located in Chapter 2, Section 1 of the *Evidence of Coverage*) to ask for a list of covered drugs that treat the same medical condition.

- **You and your doctor can ask the plan to make an exception for you** and cover the drug. To learn what you must do to ask for an exception, see the *Evidence of Coverage* that was included in the mailing with this Annual Notice of Changes. Look for Chapter 9 of the *Evidence of Coverage* (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

- **If we approve your request for an exception**, our approval usually is valid until the end of the plan year. A new formulary exception will need to be submitted for the upcoming plan year. To learn what you must do to ask for an exception, see Chapter 9 of your Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "*Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs"* (also called the *"Low Income Subsidy Rider"* or the *"LIS Rider"*), which tells you about your drug costs. If you get "Extra Help" and haven't received this insert, please call Customer Care and ask for the "LIS Rider." Phone numbers for Customer Care are located in Chapter 2, Section 1 of the *Evidence of Coverage.*

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the attached *Evidence of Coverage.*)

The Deductible Stage

PEIA Plan 1

Stage	2017 (this year)	2018 (next year)
Stage 1: Yearly Deductible Stage During this stage, you pay the full cost of your Part D drugs until you have reached the yearly deductible.	The deductible is $75	The deductible is $75

PEIA Retiree Assistance Program

Stage	2017 (this year)	2018 (next year)
Stage 1: Yearly Deductible Stage During this stage, you pay the full cost of your Part D drugs until you have reached the yearly deductible.	The deductible is $75	The deductible is $75

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

PEIA Plan 1

Stage	2017 (this year)	2018 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. The costs in this row are for a one-month 30-day supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply or for mail order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage.*	Your cost for a 30 day supply filled at a network pharmacy with standard cost-sharing $5 for Tier 1 drug 30 day supply $15 for Tier 2 drug 30 day supply $50 for Tier 3 drug 30 day supply $50 for Tier 4 drug 30 day supply _____ Once your total drug costs have reached $3700 you will move to the next stage (the Coverage Gap Stage).	Your cost for a 30 day supply filled at a network pharmacy with standard cost-sharing $5 for Tier 1 drug 30 day supply $15 for Tier 2 drug 30 day supply 50% for Tier 3 drug 30 day supply $100 for Tier 4 drug 30 day supply _____ Once your total drug costs have reached $3750 you will move to the next stage (the Coverage Gap Stage).

PEIA Retiree Assistance Program

Stage	2017 (this year)	2018 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. The costs in this row are for a one-month 30-day supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply or for mail order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage.*	Your cost for a 30 day supply filled at a network pharmacy with standard cost-sharing $3 for Tier 1 drug 30 day supply $10 for Tier 2 drug 30 day supply $50 for Tier 3 drug 30 day supply $50 for Tier 4 drug 30 day supply _____ Once your total drug costs have reached $3700 you will move to the next stage (the Coverage Gap Stage).	Your cost for a 30 day supply filled at a network pharmacy with standard cost-sharing $5 for Tier 1 drug 30 day supply $15 for Tier 2 drug 30 day supply 50% for Tier 3 drug 30 day supply $100 for Tier 4 drug 30 day supply _____ Once your total drug costs have reached $3750 you will move to the next stage (the Coverage Gap Stage).

Changes to the Catastrophic Coverage Stage

The other drug coverage stage – the Catastrophic Coverage Stage – is for people with high drug costs. **Most members do not reach the Catastrophic Coverage Stage**. For information about your costs in this stage, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage.*

SECTION 2 Deciding Which Plan to Choose

Section 2.1 If you want to stay in Humana Medicare Employer PPO

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare, you will automatically stay enrolled as a member of our plan for 2018.

Section 2.2 If you want to change plans

We hope to keep you as a member next year but if you want to change for 2018 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- --OR-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2018*, call your State Health Insurance Assistance Program (SHIP) (see "Exhibit A" in the *Evidence of Coverage*), or call Medicare. (See Section 6.2.)

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to **https://www.medicare.gov** and click "Find health & drug plans.**" Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Additionally, you may contact your former employer or union to obtain more information on electing other coverage.

Step 2: Change your coverage

- To change to a different Medicare health plan, enroll in the new plan. You will automatically be disenrolled from Humana Medicare Employer PPO.
- To change to Original Medicare with a prescription drug plan, enroll in the new drug plan. You will automatically be disenrolled from Humana Medicare Employer PPO.
- To change to Original Medicare without a prescription drug plan, you must either:
    - Send us a written request to disenroll. Contact Customer Care if you need more information on how to do this. (Phone numbers are located in Chapter 2, Section 1 of the *Evidence of Coverage*.)

- --OR-- Contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

Are there other times of the year to make a change?

- In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage.*

- If you enrolled in a Medicare Advantage Plan for January 1, 2018, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2018. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage.*

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

A State Health Insurance Assistance Program (SHIP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. State Health Insurance Assistance Program (SHIP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. Contact information for your State Health Insurance Assistance Program (SHIP) can be found in "Exhibit A" in the *Evidence of Coverage.*

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare**. People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, copayments, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:

    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call 1-800-325-0078 (applications); or
    - Your State Medicaid Office (applications).

- **Help from your state's pharmaceutical assistance program.** Many states have State Pharmaceutical Assistance Programs (SPAPs) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program. (The name and phone numbers for this organization are in "Exhibit A" in the *Evidence of Coverage*.)

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the ADAP in your state. For information on eligibility criteria, covered drugs, or how to enroll in the program, please see "Exhibit A" in the *Evidence of Coverage.*

SECTION 6 Questions?

Section 6.1 Getting Help from Humana Medicare Employer PPO

Questions? We're here to help. Please call Customer Care at the phone number located in Chapter 2, Section 1 of the *Evidence of Coverage.* (TTY only, call 711.) We are available for phone calls from 8 a.m. to 9 p.m., Eastern time, Monday through Friday. Calls to these numbers are free.

Read your 2018 *Evidence of Coverage* (it has details about next year's benefits and costs)

This Annual Notice of Changes gives you a summary of changes in your benefits and costs for 2018. For details, look in the 2018 *Evidence of Coverage* for Humana Medicare Employer PPO. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

You can also visit our website at **Humana.com**. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug Guide). (See Chapter 6, Section 1.1 of the *Evidence of Coverage* for how to access the *Drug Guide*.)

Section 6.2 Getting Help from Medicare

To get information directly from Medicare: **Call 1-800-MEDICARE (1-800-633-4227)**

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website **(https://www.medicare.gov)**. It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to **https://www.medicare.gov** and click on "Find health & drug plans".)

Read Medicare & You 2018

You can read *Medicare & You 2018 Handbook.* Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website **(https://www.medicare.gov)** or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.