2024

Summary of Benefits

Humana Gold Plus - Diabetes and Heart (HMO C-SNP) H5619-160

Indiana
Select counties in Indiana

Our service area includes the following county/counties in Indiana: Benton, Brown, Carroll, Crawford, Fountain, Franklin, Fulton, Lake, Marion, Martin, Ohio, Orange, Owen, Parke, Steuben, Switzerland, Tipton, Union, Vanderburgh, Warren.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-833-2364 (TTY: 711)**.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **Humana.com/medicare** or call **1-800-833-2364 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025.
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

Let's talk about Humana Gold Plus - Diabetes and Heart (HMO C-SNP)

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

Humana Gold Plus - Diabetes and Heart (HMO C-SNP) is a Coordinated Care HMO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, please refer to the plan's Evidence of Coverage on our website, **Humana.com/plandocuments**.

To be eligible

To join Humana Gold Plus - Diabetes and Heart (HMO C-SNP), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be diagnosed with Cardiovascular Disorders, Chronic Heart Failure, and/or Diabetes Mellitus and live in our service area.

Plan name:

Humana Gold Plus - Diabetes and Heart (HMO C-SNP)

How to reach us:

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

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

October 1 - March 31:
Call 7 days a week from 8 a.m. - 8 p.m.

April 1 - September 30:
Call Monday - Friday, 8 a.m. - 8 p.m.

Or visit our website:

Humana.com/medicare

More about Humana Gold Plus - Diabetes and Heart (HMO C-SNP)

Do you have Medicare and Medicaid? If you are a dual-eligible beneficiary enrolled in both Medicare and your state Medicaid program, you may not have to pay the medical costs displayed in this booklet and your prescription drug costs may be lower, too.

If you have Medicaid, be sure to show your Medicaid ID card in addition to your Humana membership card to make your provider aware that you may have additional coverage. Your services are paid first by Humana and then by Medicaid.

As a member you must select an in-network doctor in your service area listed in this document to act as your Primary Care Provider (PCP). Humana Gold Plus - Diabetes and Heart (HMO C-SNP) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services. You also have access to Care Managers. Care Managers are nurses or care coordinators who are skilled at helping to improve your quality of life by providing proactive support and coordinating key services to help you better manage your health. If you're managing a serious illness or chronic condition, we'll be there to support you and your doctor's plan for care.

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A healthy partnership

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

Monthly Premium, Deductible and Limits

Monthly Plan Premium	**$25.80** You must keep paying your Medicare Part B premium. If you receive premium assistance, your plan premium may be reduced.
Medical deductible *You pay the same amount as you would with Original Medicare. In 2023, the amounts are as listed. These amounts may change in 2024.	**$226*** in-network Part B deductible The following services listed are excluded from the in-network Part B deductible: Ambulance Services Chemotherapy Drugs and Administration Diabetic Monitoring Supplies Emergency Room Services Part A Services (IP, Skilled Nursing and Home Health) Medicare Covered Preventive Services Medicare Part B Covered Drugs Services not covered by Original Medicare Urgently Needed Services at Urgent Care Centers
Pharmacy (Part D) deductible	**$545**
Maximum out-of-pocket responsibility	**$8,850** in-network The most you pay for copays, coinsurance and other costs for covered medical services for the year.

Covered Medical and Hospital Benefits

INPATIENT HOSPITAL CARE	
Your plan covers an unlimited number of days for an inpatient stay	**$569** copay per day for days 1-4 **$0** copay per day for days 5-90
OUTPATIENT HOSPITAL COVERAGE Services listed below may also be covered at other places of treatment. Please refer to specific services listed in this document for additional information.	
Advanced imaging services (MRI, MRA, PET and CT scan)	**20%** of the cost
Basic radiological services (X-rays)	**20%** of the cost
Cardiac rehabilitation services	**$20** copay
Chemotherapy drugs	**20%** of the cost

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

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Covered Medical and Hospital Benefits (cont.)

Diagnostic colonoscopy	**20%** of the cost
Diagnostic mammography	**20%** of the cost
Diagnostic procedures and tests - other	**20%** of the cost
Lab services	**$0** copay
Medicare Part B covered drugs	**20%** of the cost
Mental health services	**20%** of the cost
Nuclear medicine services	**20%** of the cost
Occupational therapy	**$0** copay
Opioid treatment program services	**20%** of the cost
Physical therapy	**$0** copay
Pulmonary rehabilitation services	**20%** of the cost
Renal dialysis services	**20%** of the cost
Sleep study (facility based)	**20%** of the cost
Speech therapy	**$0** copay
Substance abuse services	**20%** of the cost
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)	**20%** of the cost
Surgery services	**20%** of the cost
Therapeutic radiology (Radiation therapy)	**20%** of the cost
Wound care	**20%** of the cost
AMBULATORY SURGERY CENTER	
Diagnostic colonoscopy	**20%** of the cost
Surgery services	**20%** of the cost
DOCTOR OFFICE VISITS	
Primary care provider (PCP)	**$0** copay
Specialist	**20%** of the cost

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Covered Medical and Hospital Benefits (cont.)

PREVENTIVE CARE	
Our plan covers many preventive services at no cost when you see an in-network provider including:	• Abdominal aortic aneurysm screening • Alcohol misuse screening & counseling • Annual Wellness Visit (AWV) • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit • Cardiovascular disease screening • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training • Glaucoma screening • HIV screening • Immunizations • Lung cancer screening • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy • Prostate cancer screening exams • Routine physical exam • Sexually transmitted infections (STIs) screening and counseling • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • "Welcome to Medicare" preventive visit Any additional preventive services approved by Medicare during the contract year will be covered.
EMERGENCY CARE	
Emergency services at emergency room	**$100** copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.
Physician and professional services at emergency room	**$0** copay
URGENTLY NEEDED SERVICES	
	20% of the cost at an urgent care center Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

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Covered Medical and Hospital Benefits (cont.)

DIAGNOSTIC SERVICES, LABS & IMAGING	
Advanced imaging services (MRI, MRA, PET and CT scan)	• Freestanding radiological facility: **20%** of the cost • Primary care physician's office: **20%** of the cost • Specialist's office: **20%** of the cost
Basic radiological services (X-rays)	• Freestanding radiological facility: **20%** of the cost • Primary care physician's office: **$0** copay • Specialist's office: **20%** of the cost • Urgent care center: **20%** of the cost
Diagnostic colonoscopy	• Ambulatory surgery center: **20%** of the cost
Diagnostic mammography	• Freestanding radiological facility: **20%** of the cost • Specialist's office: **20%** of the cost
Diagnostic procedures and tests	• Primary care physician's office: **$0** copay • Specialist's office: **20%** of the cost • Urgent care center: **20%** of the cost
Lab services	• Freestanding laboratory: **$0** copay • Primary care physician's office: **$0** copay • Specialist's office: **$0** copay • Urgent care center: **20%** of the cost
Nuclear medicine and services	• Freestanding radiological facility: **20%** of the cost
Sleep study	• Member's home: **$0** copay • Specialist's office: **20%** of the cost
Therapeutic radiology (Radiation therapy)	• Freestanding radiological facility: **20%** of the cost • Specialist's office: **20%** of the cost

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

HEARING SERVICES	
Medicare-covered hearing	**20%** of the cost
Mandatory supplemental hearing benefit	In-Network: **HER963** • **$0** copay for routine hearing exams up to 1 per year. • **$0** copay for each Advanced level hearing aid up to 1 per ear every 3 years. • **$299** copay for each Premium level hearing aid up to 1 per ear every 3 years. Hearing aid purchase includes: • Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models • Rechargeable style options available for an additional **$50** per aid. **You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (for TTY, dial 711).**
DENTAL SERVICES	
Medicare-covered dental	**20%** of the cost
Mandatory supplemental dental benefit	The cost-share indicated below is what you pay for the covered service. In-Network: **DEN810** • **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. • **$0** copay for bridge recementation, bridges-pontic, crown recementation, panoramic film or diagnostic x-rays up to 1 every 5 years. • **$0** copay for bridges-crown up to 2 every 5 years. • **$0** copay for crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime. • **$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

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- **$0** copay for emergency diagnostic exam up to 1 per year.
- **$0** copay for emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.
- **$0** copay for periodontal maintenance up to 4 per year.
- **$0** copay for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year.
- **$3,000** maximum benefit coverage amount per year for all preventive and comprehensive benefits.

Limitations and exclusions may apply. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. Dental benefits under this plan may not cover all ADA procedure codes. Any services received that are not listed will not be covered by the plan and will be the member's responsibility. The member is responsible for any amount above the dental coverage limit. Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. Information regarding each plan is available at **Humana.com/sb**.

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

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

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

VISION SERVICES	
Eyewear (post cataract surgery)	**$0** copay
Medicare-covered diabetic eye exam	**$0** copay
Medicare-covered vision services	**20%** of the cost The provider location for Medicare-covered vision can be found at **Humana.com** > Find a Doctor > select the Medical icon > enter Zip Code > select look up Method > Medicare or Medicare-Medicaid > select your plan Network > select Search Category > Specialty Physician.
Mandatory supplemental vision benefit	In-Network: **VIS733** • **$0** copay for routine exam up to 1 per year. • **$300** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • **$350** maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year. • Maximum benefit coverage amounts cannot be combined. PLUS providers are part of the **Humana Medicare Insight Network** and are indicated in the provider locator search results. The provider locator for the Humana Medicare Insight Network for Mandatory supplemental benefit vision can be found at **Humana.com** > Find a Doctor > select the Vision Care icon > select Medicare > select Medicare Advantage.

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

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Covered Medical and Hospital Benefits (cont.)

MENTAL HEALTH SERVICES	
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$484** copay per day for days 1-4 **$0** copay per day for days 5-90
Therapy visits	• Partial hospitalization: **20%** of the cost • Specialist's office: **20%** of the cost
SKILLED NURSING FACILITY (SNF)	
Your plan covers up to 100 days in a SNF	**$0** copay per admit
PHYSICAL THERAPY	
Comprehensive outpatient rehab facility	**$0** copay
Specialist's office	**$0** copay
AMBULANCE	
	20% of the cost
TRANSPORTATION	
	$0 copay for plan approved location up to unlimited one-way trip(s) per year. This benefit is not to exceed 50 miles per trip. The member *must* contact transportation vendor to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider.
MEDICARE PART B DRUGS	
Allergy shots and serum	• Primary care physician's office: **$0** copay • Specialist's office: **$0** copay
Chemotherapy drugs	• Specialist's office: **20%** of the cost
Other Part B drugs Some rebatable Part B drugs may be subject to a lower coinsurance. You pay no more than $35 for a one-month (up to 30-day) supply for all Part B insulin covered by our plan, and if your plan has a deductible it does not apply to Part B insulin.	• Pharmacy: **$0** copay • Primary care physician's office: **20%** of the cost • Specialist's office: **20%** of the cost

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Prescription Drug Benefits

PLAN HIGHLIGHTS

Insulin costs	You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by your plan
Additional gap coverage	Additional gap coverage for the following: Insulin
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

DEDUCTIBLE

This plan has a **$545** deductible. You pay the full cost of your drugs until you reach **$545**. Then, you only pay your cost-share.

INITIAL COVERAGE

You pay the following until your total yearly drug costs for covered drugs reach **$5,030**. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.

Pharmacy Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		**Mail-Order Cost-Sharing**	
Day supply	**30-day**	**90-day***	**30-day**	**90-day***
All Plan-Covered Part D Drugs	25%	25%	25%	25%

Other pharmacies are available in your network. To find which pharmacies are available in your network, go to **Humana.com/pharmacyfinder**.

*Some drugs are limited to a 30-day supply.

You won't pay more than **$35** for a one-month (up to 30-day) supply of each plan-covered insulin product, even if you haven't paid your deductible.

Insulin Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		**Mail-Order Cost-Sharing**	
Day supply	**30-day**	**90-day***	**30-day**	**90-day***
All Plan-Covered Part D Insulins	$35	$105	$35	$105

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Other pharmacies are available in your network. To find which pharmacies are available in your network, go to **Humana.com/pharmacyfinder**.

*Some drugs are limited to a 30-day supply.

COVERAGE GAP

After you enter the coverage gap, you pay **25 percent** of the plan's cost for covered brand name drugs and **25 percent** of the plan's cost for covered generic drugs until your out-of-pocket costs total **$8,000** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, **you may pay even less** for the following:

Tier 3 (Preferred Brand) - Insulin

Tier 5 (Specialty Tier) - Insulin

For more information on cost sharing in the coverage gap, please call us or access your Evidence of Coverage online.

CATASTROPHIC COVERAGE

After your yearly out-of-pocket drug costs reach **$8,000** you pay **$0** for plan-covered Part D drugs.

EXTRA HELP

If you receive "Extra Help" for your drugs you will have a **$0** deductible.

Prior to reaching your annual **$8,000** out-of-pocket limit you will pay one of the following depending on your level of "Extra Help:"

- **$4.50** for generic/preferred multi-source drug or biosimilar; **$11.20** for any other drug; OR
- **$1.55** for generic/preferred multi-source drug or biosimilar; **$4.60** for any other drug; OR
- **$0** for all drugs

After reaching your annual **$8,000** out-of-pocket limit, you will pay **$0** for the remainder of the calendar year, regardless of the level of "Extra Help" you receive. Additional information will be available on your LIS rider.

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

If you reside at an in-network long-term care facility, you pay the same as you would at an in-network retail pharmacy. Under certain situations you may be able to get drugs from an out-of-network pharmacy but may pay more than you would pay at an in-network pharmacy.

Additional Benefits

Chiropractic services (Medicare-covered)	**20%** of the cost
Podiatry services (Medicare-covered)	**20%** of the cost
Acupuncture services (Medicare-covered)	**20%** coinsurance for acupuncture for chronic low back pain visits up to 20 visit(s) per year.
MEDICAL EQUIPMENT/SUPPLIES	
Diabetic monitoring supplies	• Diabetic supplier: **20%** of the cost • Network retail pharmacy: **$0** copay • Preferred diabetic supplier: **$0** copay
Durable medical equipment (DME) and related supplies	• Durable medical equipment provider: **20%** of the cost
Medical supplies	• Medical supplier: **20%** of the cost
Prosthetic devices and related supplies	• Prosthetics provider: **20%** of the cost
REHABILITATION SERVICES	
Cardiac rehabilitation services	• Specialist's office: **20%** of the cost
Occupational therapy	• Comprehensive outpatient rehab facility: **$0** copay • Specialist's office: **$0** copay
Physical therapy	• Comprehensive outpatient rehab facility: **$0** copay • Specialist's office: **$0** copay
Pulmonary rehabilitation services	• Specialist's office: **20%** of the cost
Speech therapy	• Comprehensive outpatient rehab facility: **$0** copay • Specialist's office: **$0** copay
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)	• Specialist's office: **20%** of the cost
TELEHEALTH SERVICES (in addition to Original Medicare)	
Primary care physician's office	**$0** copay
Specialist	**20%** of the cost
Substance abuse and behavioral health services	**$0** copay
Urgent care services	**20%** of the cost

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More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.
This is a summary of what we cover. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of coverage and services. Visit **Humana.com/plandocuments** to view a copy of the EOC or call **1-800-833-2364**.

Flex Allowance

$500 annual allowance on a prepaid card to use for out-of-pocket expenses, including copays related to the current plan year covered dental, vision and hearing services.

Any unused amount expires at the end of the plan year.

This allowance can be used at **in-network** dental, vision and hearing providers that accept Visa® payments and the provider's main business is dental care, vision services, or hearing services. Limitations and restrictions may apply.

See the **Humana Spending Account Card** section for more information. Allowance amount cannot be combined with other benefit allowances which may be on the card.

Humana Spending Account Card

The Humana Spending Account Card is what you use to spend allowances included in this plan. If your previous plan had a Humana Spending Account Card, please keep using the same card. If your previous plan did not have a Humana Spending Account Card, please activate your card as soon as you receive it in the mail.

Please keep this card even after the allowance is spent as future allowance amounts will be added to this card.

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

HMO Travel Benefit

Members can receive in-network benefits when services are received from a participating HMO National Network provider during their travels to other states and Puerto Rico.

You must select an in-network doctor in your service area listed in this document to act as your Primary Care Provider (PCP).

Routine foot care

$0 copay for routine podiatry visits up to 6 visit(s) per year.

Humana Well Dine® Meal Program
Humana's home delivered meal program for members following an inpatient stay in the hospital or nursing facility.

Over-the-Counter (OTC) mail order
$300 quarterly allowance to buy approved over-the-counter health and wellness products available through our OTC Mail Order provider.
Unused amount expires at the end of the quarter.

- Quarterly allowance amounts are available to use at the beginning of January, April, July, and October.
- Limitations and restrictions may apply.

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Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable federal civil rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html.**
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

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

GHHLNNXEN 0623

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-320-1235 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-320-1235 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235（听障专线：711）。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-320-1235（聽障專線：711）。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다 . 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

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Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بخطتنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-320-1235 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-320-1235 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-320-1235 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

Japanese：当社の健康保険と処方薬プランに関するご質問にお答えするために、無料の通訳サービスをご用意しています。通訳をご用命になるには、1-877-320-1235 (TTY：711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。

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Find out **more**

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

You can see our plan's **drug guide** at our website at **humana.com/medicaredruglist** or call us at the number listed at the beginning of this booklet and we will send you one.

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

Humana has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2024 based on a review of Humana's Model of Care.

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

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

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The information you need is just a click away.

Visit Humana.com/PlanDocuments to check details about your plan, including benefits and costs.

If you'd like a printed Evidence of Coverage, Provider Directory, or Drug List mailed to you, you can request one online at the website above, or call **1-800-457-4708 (TTY: 711)**, 24 hours a day, seven days a week. Please have your Humana member ID card ready when you call. When asked for the reason you've called, say "Evidence of Coverage," "Drug List" or "Provider Directory."

Activate your secure MyHumana account.

Your online MyHumana account is an important part of your Humana membership. Use it to view your plan details anytime and access important plan documents online, all in one place. It's easy to use and tailored to you.

Already have an account?

Go to **Humana.com/MyHumanaPlan** and log in.

Don't have an account yet?

Create one using the same link above in just minutes.

Receiving information about other insurance products

As a Humana member, we may call you to offer other insurance-related products. You can opt out of those future calls by calling the Customer Care number on the back of your ID card.

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Humana Inc.
P.O. Box 14168
Lexington, KY 40512-4168

Important information about your plan

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