2025

Summary of Benefits

Humana Gold Plus - Diabetes and Heart (HMO-POS C-SNP) H0028-067

Wichita

Select Counties in Kansas

Our service area includes the following county/counties in Kansas: Douglas, Jefferson, Johnson, Leavenworth, Miami, Reno, Sedgwick, Shawnee, Wyandotte.

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

- ☐ 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 copays/coinsurance may change on January 1, 2026.
- ☐ **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.
- ☐ This plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copay/coinsurance for services received by non-contracted providers.
- ☐ 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-POS C-SNP)

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

Humana Gold Plus - Diabetes and Heart (HMO-POS 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-POS 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-POS 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-POS 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 within the service area listed in this document to act as your Primary Care Provider (PCP). Humana Gold Plus - Diabetes and Heart (HMO-POS 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 this plan — with extra services and resources provided by Humana!

Monthly Premium, Deductible and Limits

Monthly plan premium	**$40.90** You must keep paying your Medicare Part B premium. If you receive premium assistance, this plan premium may be reduced.
Part B premium reduction	Your plan will reduce your Monthly Part B premium by up to **$1** but by no more than Original Medicare's Part B Premium for 2025.
Medical deductible *You pay the same amount as you would with Original Medicare.	**$257*** in-network Part B deductible The following services listed are excluded from the in-network Part B deductible: • Ambulance Services • Chemotherapy Drugs and Administration • Continuous Glucose Monitors • Diabetic Monitoring Supplies • Emergency Room Services • Part A Services (IP, Skilled Nursing and Home Health) • Medicare Covered Preventive Services • Medicare Part B Insulin Drugs • Other Medicare Part B Drugs • Services not covered by Original Medicare • Urgently Needed Services at Urgent Care Centers
Pharmacy (Part D) deductible	**$0** deductible for Tier 1 and Tier 6 **$590** deductible for Tier 2, Tier 3, Tier 4 and Tier 5
Maximum out-of-pocket responsibility	**$9,350** in-network The most you pay for copays, coinsurance and other costs for covered medical services for the year.

Medical Benefits

INPATIENT HOSPITAL COVERAGE	
This plan covers an unlimited number of days for an inpatient stay	**$2,165** copay per admit
OUTPATIENT HOSPITAL COVERAGE	
Diagnostic colonoscopy	**20%** of the cost
Diagnostic mammography	**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 this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

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Medical Benefits (cont.)

Surgery services	**20%** of the cost
AMBULATORY SURGERY CENTER	
Diagnostic colonoscopy	**20%** of the cost
Surgery services	**20%** of the cost
DOCTOR VISITS	
Primary Care Provider (PCP)	• PCP's office: **20%** of the cost • Telehealth: **$0** copay
Specialist	• Specialist's office: **20%** of the cost • Telehealth: **20%** of the cost
PREVENTIVE CARE	
This plan covers all Medicare preventive services 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 screenings** • **Cervical and vaginal cancer screening** • **Colorectal cancer screening** • **Depression screening** • **Diabetes screenings** • **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** • **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.	**$0** copay

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Medical Benefits (cont.)

EMERGENCY CARE	
Emergency services at emergency room If you are admitted to the same hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	**$110** copay
Physician and professional services at emergency room	**$0** copay
URGENTLY NEEDED SERVICES	
Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	• Telehealth: **20%** of the cost • Urgent care center: **20%** of the cost
DIAGNOSTIC SERVICES, LABS & IMAGING	
Advanced imaging services (MRI, MRA, PET and CT scan)	• Freestanding radiological facility: **$300** copay • Outpatient hospital: **$350** copay • PCP's office: **$300** copay • Specialist's office: **$300** copay
Basic radiological services (X-rays)	• Freestanding radiological facility: **20%** of the cost • Outpatient hospital: **20%** of the cost • PCP's office: **20%** of the cost • Specialist's office: **20%** of the cost • Urgent care 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	• Outpatient hospital: **20%** of the cost • PCP's office: **20%** of the cost • Specialist's office: **20%** of the cost • Urgent care center: **20%** of the cost
Lab services	• Freestanding laboratory: **$30** copay • Outpatient hospital: **20%** of the cost • PCP'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 • Outpatient hospital: **20%** of the cost

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Medical Benefits (cont.)

Sleep study	• Member's home: **$0** copay • Outpatient hospital: **20%** of the cost • Specialist's office: **20%** of the cost
Therapeutic radiology (Radiation therapy)	• Freestanding radiological facility: **20%** of the cost • Outpatient hospital: **20%** of the cost • Specialist's office: **20%** of the cost
HEARING SERVICES	
Medicare-covered hearing	**20%** of the cost
Mandatory supplemental hearing benefit	In-Network: **HER937** • **$0** copay for routine hearing exams up to 1 per year. • **$699** copay for each Advanced level hearing aid up to 1 per ear per year. • **$999** copay for each Premium level hearing aid up to 1 per ear per year. 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 Premium and Advanced aids 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 (TTY: 711).**
DENTAL SERVICES	
Medicare-covered dental	**20%** of the cost
Mandatory supplemental dental benefit 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.	In-Network: **DEN389** • **$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, complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years. • **$0** copay for bridges-crown up to 2 every 5 years.

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

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 any applicable coinsurance payment still applies).

Out-of-network dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Members may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Please see below for provider locator instructions. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement. The coinsurance level will apply to the average negotiated in-network fee schedule (INFS) in your area. See Chapter 2 Payment Requests Contact Information in your Evidence of Coverage or visit **Humana.com** for information on requesting reimbursement.

When visiting an out-of-network provider there could be a difference between Humana's reimbursement and the dentist's charges. Members are responsible for this difference when visiting an out-of-network provider; this is known as balanced billing.

Find a dentist in the nationwide Humana Dental Medicare network at **Humana.com** > Find Care.

- **$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.
- **$0** copay for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year.
- **$0** copay for emergency treatment for pain, 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.
- **$4,000** combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.

Out-of-Network:

DEN389

- **$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, complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures 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.
- **$0** copay for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 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 this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

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	• **$0** copay for emergency treatment for pain, 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. • **$4,000** combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
VISION SERVICES	
Eyewear (post cataract surgery)	**20%** of the cost
Medicare-covered diabetic eye exam	**$0** copay
Medicare-covered vision services The provider locator for Medicare-covered vision can be found at **Humana.com** > Find Care.	**20%** of the cost
Mandatory supplemental vision benefit The mandatory supplemental vision benefits are provided through the Humana Medicare Insight Network. The provider locator can be found at **Humana.com** > Find Care.	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. • OR • **$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.

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

Medical Benefits (cont.)

MENTAL HEALTH SERVICES	
Inpatient This plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$2,016** copay per admit
Mental health therapy visits	• Outpatient hospital: **20%** of the cost • Partial hospitalization: **20%** of the cost • Specialist's office: **20%** of the cost
Outpatient substance abuse services	• Outpatient hospital: **20%** of the cost • Partial hospitalization: **20%** of the cost • Specialist's office: **20%** of the cost • Telehealth: **20%** of the cost
SKILLED NURSING FACILITY (SNF)	
This plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$214** copay per day for days 21-100
AMBULANCE	
Air	**20%** of the cost
Ground	**$315** copay per date of service
TRANSPORTATION	
The member *must* contact transportation vendor to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider.	**$0** copay for plan approved location up to 24 one-way trip(s) per year. This benefit is not to exceed 25 miles per trip.
MEDICARE PART B DRUGS Some rebatable Part B drugs may be subject to a lower coinsurance	
Allergy shots and serum	• PCP's office: **$0** copay • Specialist's office: **$0** copay
Chemotherapy drugs	• Outpatient hospital: **20%** of the cost • Specialist's office: **20%** of the cost
Other Part B drugs	• Outpatient hospital: **20%** of the cost • PCP's office: **20%** of the cost • Pharmacy: **$0** copay • Specialist's office: **20%** of the cost
Part B Insulin You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan.	• Outpatient hospital: **20%** of the cost • PCP's office: **20%** of the cost • Pharmacy: **$0** copay • 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 this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

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Prescription Drug Benefits

PLAN HIGHLIGHTS

$0 Rx Copay Benefit	If you receive "Extra Help," you will pay **$0** for all Medicare Part D plan-covered prescription drugs for the entire calendar year. If you do not receive "Extra Help" see details below.
$0 copays	**$0** copays at select pharmacy locations and tiers. Additional details below.
Deductible	**$0** deductible for Tier 1 and Tier 6
Insulin costs	You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan.
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

DEDUCTIBLE

$0 deductible for Tier 1 and Tier 6. This plan has a **$590** deductible for Tier 2, Tier 3, Tier 4 and Tier 5 drugs. You pay the full cost of these drugs until you reach **$590**. Then, you only pay your cost-share.

INITIAL COVERAGE

You pay the following until your total out-of-pocket costs reach **$2,000**. Once you reach this amount, you will enter the Catastrophic Stage.

Pharmacy Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		**Standard Mail-Order Cost-Sharing**		**Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy™	
Day supply	**30-day**	**90-day***	**30-day**	**90-day***	**30-day**	**90-day***
Tier 1: Preferred Generic	$0	$0	$10	$30	$0	$0
Tier 2: Generic	$5	$15	$20	$60	$5	$0
Tier 3: Preferred Brand	$47	$141	$47	$141	$47	$131
Tier 4: Non-Preferred Drug	$100	$300	$100	$300	$100	$290
Tier 5: Specialty Tier	25%	N/A	25%	N/A	25%	N/A
Tier 6: Select Care Drugs	$0	$0	$0	$0	$0	$0

You have several options for filling your prescriptions, including retail and mail-order pharmacies. CenterWell Pharmacy® is the preferred mail-order, cost-sharing pharmacy for many Humana plans, which means you may pay as little as **$0** for certain Tier 1 and Tier 2 generics. Learn more at **CenterWellPharmacy.com**.

Other pharmacies are available in our network. To find which pharmacies are available in our 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 regardless of cost-sharing tier, even if you haven't paid your deductible.

Insulin Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		**Standard Mail-Order Cost-Sharing**		**Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy™	
Day supply	**30-day**	**90-day***	**30-day**	**90-day***	**30-day**	**90-day***
Tier 3: Preferred Brand	$35	$105	$35	$105	$35	$95
Tier 5: Specialty Tier	$35	N/A	$35	N/A	$35	N/A

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

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

CATASTROPHIC COVERAGE

After your total out-of-pocket costs reach **$2,000** you pay **$0** for plan-covered Part D drugs.

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 (TTY: 1-800-325-0778), Monday – Friday, 7 a.m. – 7 p.m. 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

Acupuncture services (Medicare-covered)	**20%** coinsurance for acupuncture for chronic low back pain visits up to 20 visit(s) per year.
Chiropractic services (Medicare-covered)	**20%** of the cost
Podiatry services (Medicare-covered)	**20%** of the cost

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Additional Benefits (cont.)

MEDICAL EQUIPMENT/SUPPLIES	
Continuous glucose monitor (CGM)	• DME provider **19%** of the cost • Pharmacy: **$0** copay
Diabetic monitoring supplies	• Diabetic supplier: **20%** of the cost • Network retail pharmacy: **$0** copay • Preferred diabetic supplier: **$0** copay
Durable medical equipment (DME)	• DME provider: **19%** 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	• Outpatient hospital: **20%** of the cost • Specialist's office: **20%** of the cost
Occupational therapy	• Comprehensive outpatient rehab facility: **20%** of the cost • Outpatient hospital: **20%** of the cost • Specialist's office: **20%** of the cost
Physical therapy	• Comprehensive outpatient rehab facility: **20%** of the cost • Outpatient hospital: **20%** of the cost • Specialist's office: **20%** of the cost
Pulmonary rehabilitation services	• Outpatient hospital: **20%** of the cost • Specialist's office: **20%** of the cost
Speech therapy	• Comprehensive outpatient rehab facility: **20%** of the cost • Outpatient hospital: **20%** of the cost • Specialist's office: **20%** of the cost
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)	• Outpatient hospital: **20%** of the cost • Specialist's office: **20%** of the cost

More benefits with **this plan**

Enjoy some of these extra benefits included in this 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**.

Humana Healthy Options Allowance™*

$150 monthly allowance on a prepaid card to use for essentials you need to support your health.

This allowance can be used to buy approved products from participating retail locations (like groceries, over-the-counter health and wellness items, personal care items, home supplies, etc.) or pay for approved services (monthly living expenses like rent, non-medical transportation costs like a taxi, Uber, Lyft, etc.).

Allowance amount cannot be combined with other allowances which may be on the Card.

Unused amount rolls over to the next month and expires at the end of the plan year.

- Allowance is available to use at the beginning of every month.
- Limitations and restrictions may apply.

See the Humana Spending Account Card section for more information.

Humana Spending Account Card

The Humana Spending Account Card is what you use to spend allowances included in this plan. If you currently have a Humana Spending Account Card please keep using it. Allowances will continue to be loaded to this card. If you do not have a card, one will be sent to you. Please activate your card as soon as you receive it in the mail.

- 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 within the service area listed in this document to act as your Primary Care Provider (PCP).

* Benefit(s) mentioned may be part of a special supplemental program for chronically ill members with one of the following conditions: Diabetes mellitus, Cardiovascular disorders, Chronic and disabling mental health conditions, Chronic lung disorders, Chronic heart failure. This is not a complete list of qualifying conditions. Having a qualifying condition alone does not mean you will receive the benefit(s). Other requirements may apply.

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Humana Well Dine® Meal Program
$0 copayment for Humana Well Dine® meal program.

After your inpatient stay in either a hospital or a nursing facility, you may be eligible to receive 2 home delivered meals per day for 7 days (up to 14 meals).

Meals must be requested within 30 days of discharge from your inpatient stay.

Limited to 4 times per year.

Post Discharge Personal Home Care
$0 copay for a minimum of 4 hours per day, up to a maximum of 44 hours per year for certain in-home support services following a discharge from a skilled nursing facility or from an inpatient hospitalization.

Qualified aides can offer assistance performing activities of daily living (ADLs) Activities of daily living are activities related to personal care.

They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.

When a member is receiving assistance with one or more Activities of Daily Living (ADLs), they may also receive assistance with Instrumental Activities of Daily living (IADLs) within the home by a qualified aide.

IADLs are activities related to independent living.

They include preparing meals, pick up of pre-paid curbside/drive-through orders, performing light housework, laundry, dishes, and/or using a telephone.

A member must be receiving assistance with a minimum of one ADL to receive assistance with any IADL.

Services must be initiated within 30 days of discharge event and utilized within 60 days of discharge for each qualifying event up to the maximum annual allowance.

This benefit also allows Caregivers to take a break while the member continues to get care in a safe environment.

Rewards and Incentives - Go365® by Humana
Complete eligible healthy activities, like preventive screenings and exams, and get rewarded.

Notes

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Notes

Notice of Non-Discrimination

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Humana Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

- U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019, 800-537-7697 (TDD)**.

This notice is available at **www.humana.com/legal/non-discrimination-disclosure**.

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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**

Need help finding a doctor or pharmacy? You can see this plan's **Provider and Pharmacy Directory** at our website at **Humana.com/Find-Care** or call us at the number listed at the beginning of this booklet and we will send you one. Many doctor listings include a Care Highlight® rating. These ratings in clinical quality and cost-efficiency can help you make informed choices about your healthcare. Ratings only appear when we have enough information to measure a doctor's clinical quality and cost-efficiency. Learn more at **Humana.com/CareHighlight**.

You can see this 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.

Clinical quality and cost-efficiency ratings are available in all states except Alaska. Ratings are not available for all physicians. Care Highlight is intended for informational purposes only. Members have access to all physicians in the Humana network, regardless of whether or not the physician has a Care Highlight rating. Ratings should not be the sole basis for selecting a doctor. Humana does not give performance-based payments to doctors based on these ratings. Ratings do not guarantee the quality or outcome of healthcare services.

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 Gold Plus - Diabetes and Heart (HMO-POS C-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2025 based on a review of Humana Gold Plus - Diabetes and Heart (HMO-POS C-SNP) 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 this plan may cover or other rules that may apply.

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

The Part B Premium Reduction benefit pays part or all of your Part B premium and the amount may change based on the amount you pay for Part B.

More information is just a click away.

Visit **Humana.com/PlanDocuments** to see additional details about this plan, including benefits and costs.

If you'd like a printed Evidence of Coverage, Provider Directory, or Drug Guide 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 Guide" or "Provider Directory."

Activate your secure MyHumana account.

Your online MyHumana account is an important part of your Humana membership. Use it to view this plan's 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/Member/ManageYourAccount** 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 any future calls using 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 this plan

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