Summary of Benefits

HumanaChoice - Diabetes and Heart (PPO C-SNP) H5216-334

Mississippi

Select Counties in Mississippi

Our service area includes the following county/counties in Mississippi: Adams, Alcorn, Attala, Bolivar, Chickasaw, Choctaw, Claiborne, Coahoma, Covington, DeSoto, Franklin, George, Greene, Harrison, Hinds, Humphreys, Jackson, Jasper, Jones, Lamar, Lauderdale, Leflore, Marion, Panola, Pike, Quitman, Scott, Sharkey, Stone, Sunflower, Tallahatchie, Tate, Tishomingo, Tunica, Walthall, Washington, Wayne, Yalobusha.

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 **800-833-2364 (TTY: 711)**.

Unde	rstanding 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 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 (Drug Guide) to make sure your drugs are covered.
Unde	rstanding 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, 2027.
	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 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 HumanaChoice - Diabetes and Heart (PPO C-SNP)

Find out more about the HumanaChoice - Diabetes and Heart (PPO C-SNP) plan - including the health and drug services it covers - in this easy-to-use booklet.

HumanaChoice - Diabetes and Heart (PPO C-SNP) is a Special Needs 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 HumanaChoice - Diabetes and Heart (PPO 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

HumanaChoice - Diabetes and Heart (PPO C-SNP)

How to reach us

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

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

You can call us seven days a week from 8 a.m. to 8 p.m. Please note that our automated phone system may answer your call during weekends and holidays. Or visit our website:

Humana.com/Medicare

More about HumanaChoice - Diabetes and Heart (PPO 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 it's a good idea to select a doctor as your Primary Care Provider (PCP).
HumanaChoice - Diabetes and Heart (PPO C-SNP) has a network of doctors, hospitals, pharmacies and other providers.

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.



A healthy partnership

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



Monthly Premium, Deductible and Limits

PL	AN	C	0	S	rs

Monthly plan premium	\$0 You must keep paying your Medicare Part B premium.
Medical deductible	\$400 combined The following services listed are excluded from the combined in-network and out-of-network deductible:
	In-Network only: Ambulance Services
	Chemotherapy Drugs and Administration Continuous Glucose Monitor
	Diabetic Monitoring Supplies
	Diagnostic Colonoscopy Diagnostic Mammography
	Durable Medical Equipment Lab Services
	Other Medicare Part B Drugs
	Outpatient Blood Services Primary Care Physician's Office
	Specialist's Office
	Both In-Network and Out-of-Network:
	Emergency Room Services Medicare Covered Preventive Services
	Medicare Part B Insulin Drugs
	Services not covered by Original Medicare (i.e., Supplemental Benefits) Urgently Needed Services at Urgent Care Centers
Pharmacy (Part D) deductible	\$0 deductible for Tier 1, Tier 2, Tier 3 and Tier 6 \$615 deductible for Tier 4 and Tier 5
Medical Maximum out-of-pocket responsibility	\$6,700 in-network \$6,700 combined in- and out-of-network
	The most you pay for copays, coinsurance and other costs for covered medical services for the year.

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.

Medical Benefits		
	IN-NETWORK	OUT-OF-NETWORK
INPATIENT HOSPITAL COVERAGE		
This plan covers an unlimited number of days for an inpatient stay.	\$295 copay per day for days 1-7 \$0 copay per day for days 8-90	35% of the cost
OUTPATIENT HOSPITAL COVERAGE		
Diagnostic colonoscopy	\$0 copay	\$0 copay
Diagnostic mammography	\$0 copay	\$0 copay
Surgery services	\$300 copay	\$300 copay
AMBULATORY SURGERY CENTER		
Diagnostic colonoscopy	\$0 copay	\$0 copay
Surgery services	\$200 copay	\$250 copay
DOCTOR VISITS		
Primary care provider (PCP)PCP's officeTelehealth	\$0 copay \$0 copay	\$20 copay Not Covered
SpecialistSpecialist's officeTelehealth	\$15 copay \$15 copay	\$55 copay Not Covered
PREVENTIVE CARE		
This plan covers all Medicare preventive services including: Cancer Screenings Breast cancer screening (mammogram) Cervical and vaginal cancer screening Colorectal cancer screening Lung cancer screening Prostate cancer screening	\$0 copay	\$0 copay
 Cardiovascular (heart) Care Abdominal aortic aneurysm screening Cardiovascular disease risk reduction visit Cardiovascular disease screenings 		

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.

IN-NETWORK

OUT-OF-NETWORK

Diabetes Care

- Diabetes screenings
- Diabetes self-management training
- Medicare Diabetes Prevention Program (MDPP)

Dietary Guidance and Support

- Medical nutrition therapy
- Obesity screening and therapy

Routine Screenings and Immunizations

- Annual Wellness Visit (AWV)
- Immunizations
- Routine physical exam
- "Welcome to Medicare" preventive visit

Screenings and Counseling Services

- · Bone mass measurement
- · Depression screening
- Glaucoma screening
- HIV screening
- Screening & counseling to reduce alcohol misuse
- Sexually transmitted infections (STIs) screening and counseling
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)

Any additional preventive services approved by Medicare during the contract year will be covered.

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.

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EMERGENCY CARE			
Emergency services at	\$130 copay	\$130 copay	

TN_NETWORK

If you are admitted to the same hospital within 24 hours for the same condition, you pay \$0 for the emergency care you received.

emergency room

We cover emergency services worldwide. If you have an emergency outside of the U.S. and its territories, you will be responsible to pay for the rendered service(s) upfront and can request reimbursement.

When placed in observation, member pays observation cost-share instead of emergency room cost-share.

URGENTLY NEEDED SERVICES

TelehealthUrgent care center

Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical attention. We cover urgently needed services worldwide. If you have an urgently needed service outside of the U.S. and its territories, you will be responsible to pay for the rendered service(s) upfront and can request reimbursement.

\$50 copay **\$50** copay

Not Covered \$50 copay

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You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.

Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK		
DIAGNOSTIC SERVICES, LABS AND IMAGING				
Advanced imaging services				
(MRI, MRA, PET and CT scans)Freestanding radiological	¢200 congy	¢200 congy		
facility	\$200 copay	\$300 copay		
 Outpatient hospital 	\$335 copay	\$335 copay		
• PCP's office	\$280 copay	\$300 copay		
Specialist's office	\$280 copay	\$300 copay		
Basic radiological services				
(X-rays)Freestanding radiological	\$50 copay	35% of the cost		
facility	330 Copuy	33 % of the cost		
 Outpatient hospital 	\$130 copay	35% of the cost		
PCP's office	\$0 copay	\$20 copay		
Specialist's office Urgant says senter	\$15 copay	\$55 copay		
• Urgent care center	\$50 copay	\$50 copay		
Diagnostic mammographyFreestanding radiological	¢0 congy	¢0 congy		
facility	\$0 copay	\$0 copay		
 Specialist's office 	\$0 copay	\$0 copay		
Diagnostic procedures and tests	5			
Outpatient hospital	\$95 copay	35% of the cost		
PCP's office Considiate office	\$0 copay	\$20 copay		
Specialist's officeUrgent care center	\$15 copay \$50 copay	\$55 copay \$50 copay		
Lab services	330 Copuy	330 copay		
 Freestanding laboratory 	\$0 copay	35% of the cost		
 Outpatient hospital 	\$50 copay	35% of the cost		
PCP's office	\$0 copay	\$0 copay		
 Specialist's office 	\$0 copay	\$0 copay		
Urgent care center	\$50 copay	\$50 copay		
Nuclear medicine and services				
Freestanding radiological facility	\$200 copay	\$300 copay		
facility • Outpatient hospital	\$780 copay	\$780 copay		
Sleep study	7700 copay	47.00 copuy		
Member's home	\$0 copay	\$0 copay		
Outpatient hospital	\$100 copay	35% of the cost		
 Specialist's office 	\$15 copay	\$55 copay		

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.

Humana.

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Medical Benefits (cont.)			
	IN-NETWORK	OUT-OF-NETWORK	
 Therapeutic radiology (Radiation therapy) Freestanding radiological facility Outpatient hospital Specialist's office 	20% of the cost20% of the cost\$15 copay	35% of the cost 35% of the cost \$55 copay	
HEARING SERVICES			
Medicare-covered hearing	\$15 copay	\$55 copay	
Mandatory supplemental hearing benefit	 *\$0 copay for routine hearing exams up to 1 per year. *\$199 copay for each Advanced level hearing aid up to 1 per ear per year. *\$499 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 	Hearing aids must be purchased through TruHearing. Coverage will not be provided for hearing aids purchased from a non-participating provider.	

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.

Advanced aids for an additional

You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an

appointment (TTY: 711).

\$50 per aid

Medical Benefits (cont.)

IN-NETWORK

OUT-OF-NETWORK



DENTAL SERVICES

Medicare-covered dental

Mandatory supplemental dental benefit

Limitations and exclusions may apply. Please see your Evidence of Coverage (EOC) for additional details. 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 annual maximum benefit coverage amount. 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 any applicable coinsurance payment still applies). Visiting an in-network provider may result in

\$15 copay

DEN088

- Plan covers up to \$2,000
 allowance every year for
 non-Medicare covered
 preventive and comprehensive
 dental services.
- You are responsible for any amount above the dental coverage limit.
- Any amount unused at the end of the year will expire.
- Your benefit can be used for most dental treatments such as:
- Preventive dental services, such as exams, routine cleanings, etc.
- Basic dental services, such as fillings, extractions, etc.
- Major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges etc.
- Note: The allowance cannot be used on fluoride, cosmetic services and implants.

\$55 copay

DEN088

- Plan covers up to \$2,000
 allowance every year for
 non-Medicare covered
 preventive and comprehensive
 dental services.
- You are responsible for any amount above the dental coverage limit.
- Any amount unused at the end of the year will expire.
- Your benefit can be used for most dental treatments such as:
- Preventive dental services, such as exams, routine cleanings, etc.
- Basic dental services, such as fillings, extractions, etc.
- Major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges etc.
- Note: The allowance cannot be used on fluoride, cosmetic services and implants.
- Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.

IN-NETWORK

OUT-OF-NETWORK

significant savings. The
Mandatory Supplemental Dental
benefits are provided through the
Humana Dental Medicare
Network. The provider locator for
our nationwide network can be
found at **Humana.com/FindCare**.

Out-of-network dentists have not agreed to provide services at contracted fees. The out-of-network provider may bill the member for more that what the plan pays, even for services listed with no member cost share. Members are responsible for this difference between Humana's reimbursement and the out-of-network provider's charges. This is known as balance billing. 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 above 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 usual and customary fees in your area. See Chapter 2 Payment Requests Contact Information in your Evidence of Coverage or visit

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.

IN-NETWORK

OUT-OF-NETWORK

Humana.com for information on requesting reimbursement.

VISION SERVICES

VISION SERVICES		
Eyewear (post cataract surgery)	\$0 copay	\$0 copay
Medicare-covered diabetic eye exam	\$0 copay	\$0 copay
Medicare-covered vision services The provider locator for Medicare-covered vision can be found at Humana.com/FindCare.	\$15 copay	\$55 copay

Mandatory supplemental vision benefit

benefit Please inform the network provider that you are part of the Humana Medicare Insight Network. NOTE: The network of providers for your supplemental vision benefits through Humana Medicare Insight Network may be different than the network of providers for the Medicare-covered vision benefits. The provider locator can be found at Humana.com/FindCare. Benefit allowance is applied toward the retail price. Member is responsible for any costs above the plan approved amount. Lost or broken materials are not covered. This benefit is limited to a one-time use per year. Any

This benefit is limited to a one-time use per year. Any remaining benefit dollars do not "roll over" to a future purchase. Eyeglass lens options may be available with the maximum

VIS711

- **\$0** copay for routine exam up to 1 per year.
- **\$40** combined maximum benefit coverage amount per year for routine exam.
- \$250 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.

VIS711

- **\$0** copay for routine exam up to 1 per year.
- \$40 combined maximum benefit coverage amount per year for routine exam.
- \$250 combined maximum benefit coverage amount per year 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.
- Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
- Maximum benefit coverage amounts cannot be combined.

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.

OUT-OF-NETWORK



Medical Benefits (cont.)

benefit coverage amount up to one pair per year. Benefits are offered on a	 Maximum benefit coverage amounts cannot be combined. PLUS providers are part of the 	
calendar basis. Any amount unused by the end of the year	Humana Medicare İnsight Network and will display the PLUS	
will expire.	Provider indicator in the provider	
Copayments, coinsurances, and deductibles paid for	locator search results found at Humana.com/FindCare .	
supplemental benefits do not count toward your maximum out-of-pocket amount.		
MENTAL HEALTH SERVICES		
Inpatient This plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	\$267 copay per day for days 1-7 \$0 copay per day for days 8-90	35% of the cost
Mental health therapy visits		C.I
Outpatient hospitalSpecialist's officeTelehealth	\$35 copay \$35 copay \$35 copay	35% of the cost \$55 copay Not Covered
Outpatient substance abuse services		
Outpatient hospitalSpecialist's officeTelehealth	\$35 copay \$35 copay \$35 copay	35% of the cost \$55 copay Not Covered
SKILLED NURSING FACILITY (SNF)	
This plan covers up to 100 days in a SNF	\$0 copay per day for days 1-20 \$218 copay per day for days 21-100	35% of the cost for days 1-100
AMBULANCE		
Air	20% of the cost	20% of the cost

IN-NETWORK

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.

Medical Benefits (cont.)

be directed to their plan's specific

transportation provider.

IN-NETWORK OUT-OF-NETWORK TRANSPORTATION Mandatory supplemental **\$0** copay for plan approved The in-network provider must be transportation benefit location up to 48 one-way trip(s) used for this service. The member **must** contact per year. If you choose to utilize another transportation vendor at least 72 This benefit is not to exceed 75 provider, you are responsible for hours (3 business days) in miles per trip. all charges. advance of their appointment to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider. Uniformity flexibility **\$0** copayment for plan approved The in-network provider must be non-emergency medical location up to unlimited one-way used for this service. trip(s) per year for members with transportation benefit If you choose to utilize another a Chronic Kidney Disease (CKD), The member **must** contact provider, you are responsible for transportation vendor at least 72 End Stage Renal Disease (ESRD), or all charges. Cancer Diagnosis. hours (3 business days) in advance of their appointment to This benefit is not to exceed 75 arrange transportation and miles per trip. should contact Customer Care to

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.

•	·	
	IN-NETWORK	OUT-OF-NETWORK
MEDICARE PART B DRUGS Some rebatable Part B drugs may	pe subject to a lower coinsurance.	
Allergy shots and serumPCP's officeSpecialist's office	\$0 copay \$0 copay	\$0 copay \$0 copay
Chemotherapy drugsOutpatient hospitalSpecialist's office	20% of the cost 20% of the cost	20% of the cost 20% of the cost
Other Part B drugs Outpatient hospital PCP's office Pharmacy Specialist's office	20% of the cost 20% of the cost 20% of the cost 20% of the cost	20% of the cost 20% of the cost 20% of the cost 20% of the cost
 Part B Insulin Outpatient hospital PCP's office Pharmacy Specialist's office You won't pay more than \$35 for a one-month (up to 30-day) supply of each insulin product covered by this plan. 	20% of the cost 20% of the cost 20% of the cost 20% of the cost	20% of the cost 20% of the cost 20% of the cost 20% of the cost

You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.

Prescription Drug Benefits			
PLAN HIGHLIGHTS			
\$0 copays	\$0 copays at select pharmacy locations and tiers. Additional details below.		
Deductible	\$0 deductible for Tier 1, Tier 2, Tier 3 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.		
100-day supply	Up to 100-day supply on eligible drugs		
Excluded drug coverage	Additional drug coverage for the following: Erectile dysfunction (ED) drugs Prescription vitamins		
\$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, Tier 2, Tier 3 and Tier 6. This plan has a **\$615** deductible for Tier 4 and Tier 5 drugs. You pay the full cost of these drugs until you reach **\$615**. Then, you only pay your cost-share.

INITIAL COVERAGE

You pay the following until your total yearly out-of-pocket drug costs reach **\$2,100**. Once you reach this amount, you will enter the Catastrophic Stage.

Pharmacy Cost-Sharing						
	Includes all	Retail Cost-Sharing ncludes all in-network retail pharmaciesStandard Mail-Order Cost-SharingPreferred M Cost-SharingCost-Sharing CenterWell Ph				haring
Day supply	30-day	100-day*	30-day	100-day*	30-day	100-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	\$94
Tier 4: Non-Preferred Drug	47%	47%	47%	47%	47%	47%
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 and others may be eligible for up to a 100-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	100-day*	30-day	100-day*	30-day	100-day*
Tier 1: Preferred Generic	\$0	\$0	25% up to \$10	25% up to \$30	\$0	\$0
Tier 2: Generic	25% up to \$5	25% up to \$15	25% up to \$20	25% up to \$60	25% up to \$5	\$0
Tier 3: Preferred Brand	25% up to \$35	25% up to \$105	25% up to \$35	25% up to \$105	25% up to \$35	25% up to \$70
Tier 4: Non-Preferred Drug	25% up to \$35	25% up to \$105	25% up to \$35	25% up to \$105	25% up to \$35	25% up to \$105
Tier 5: Specialty Tier	25% up to \$35	N/A	25% up to \$35	N/A	25% up to \$35	N/A
Tier 6: Select Care Drugs	\$0	\$0	\$0	\$0	\$0	\$0

^{*}Not all tiers may include insulin. Please refer to your Prescription Drug Guide to confirm insulin coverage.

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

CATASTROPHIC COVERAGE

After your total out-of-pocket costs reach **\$2,100** you pay **\$0** for plan-covered Part D and Excluded drugs.

EXCLUDED DRUG COVERAGE	
Erectile dysfunction (ED) drugs	Covered at Tier 1 cost-share amount.
Prescription vitamins	Covered at Tier 1 cost-share amount.

^{*}Some drugs are limited to a 30-day supply and others may be eligible for up to a 100-day supply.

EXTRA HELP

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

Prior to reaching your annual **\$2,100** out-of-pocket limit, you will pay one of the following depending on your level of Extra Help:

- \$5.10 for generic/preferred multi-source drug or biosimilar; \$12.65 for any other drug; OR
- \$1.60 for generic/preferred multi-source drug or biosimilar; \$4.90 for any other drug; OR
- **\$0** for all drugs

After reaching your annual **\$2,100** 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 800-772-1213 (TTY: 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 Benefi	ts	
·	IN-NETWORK	OUT-OF-NETWORK
Acupuncture services (Medicare-covered)	\$15 copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.	\$15 copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Chiropractic services (Medicare-covered)	\$15 copay	\$55 copay
Podiatry services (Medicare-covered)	\$15 copay	\$55 copay
MEDICAL EQUIPMENT/SUPPLIES	S	
Continuous glucose monitor (CGM)		
DME providerPharmacy	\$0 copay \$0 copay	\$0 copay \$0 copay

Diabetic monitoring supplies		
 Diabetic monitoring supplies Diabetic supplier 	20% of the cost	20% of the cost
Network retail pharmacy	\$0 copay	20% of the cost
 Preferred diabetic supplier 	\$0 copay	Not Covered
Durable medical equipment (DME)	20% of the cost	20% of the cost
Medical supplies at medical supplier	20% of the cost	20% of the cost
Prosthetics devices and related supplies at prosthetics provider	20% of the cost	20% of the cost
REHABILITATION SERVICES		
Cardiac rehabilitation services		
 Outpatient hospital 	\$15 copay	\$15 copay
Specialist's office	\$15 copay	\$15 copay
Occupational therapy		
 Comprehensive outpatient rehab facility 	\$25 copay	\$25 copay
 Outpatient hospital 	\$25 copay	\$55 copay
• Specialist's office	\$25 copay	\$25 copay
Physical therapy		
 Comprehensive outpatient rehab facility 	\$25 copay	\$25 copay
 Outpatient hospital 	\$25 copay	\$55 copay
 Specialist's office 	\$25 copay	\$25 copay
Pulmonary rehabilitation		
 Outpatient hospital 	\$15 copay	\$15 copay
Specialist's office	\$15 copay	\$15 copay
Speech therapy		
 Comprehensive outpatient rehab facility 	\$25 copay	\$25 copay
 Outpatient hospital 	\$25 copay	\$55 copay
• Specialist's office	\$25 copay	\$25 copay
Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD)		
Outpatient hospital	\$15 copay	\$15 copay
 Specialist's office 	\$15 copay	\$15 copay



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 **800-833-2364**.

Travel Coverage

The PPO national network gives you in-network coverage across the country, so you can see any doctor who accepts the plan terms and conditions. You'll be able to travel with ease or split your time between locations. Visit **Humana.com** or contact Customer Care on the back of your ID card if you need help finding an in-network provider.

Routine Chiropractic services

- In-network: \$15 copay for routine chiropractic visits up to 12 visit(s) per year.
- Out-of-network: \$15 copay for routine chiropractic visits up to 12 visit(s) per year.

Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Routine foot care

- In-network: \$15 copay for routine podiatry visits up to 6 visit(s) per year.
- Out-of-network: **\$15** copay for routine podiatry visits up to 6 visit(s) per year.

Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Humana Well Dine® Meal Program

Humana's meal program for members with certain special needs plans (SNPs), specific conditions or following an inpatient stay in the hospital or nursing facility. Meal delivery must be scheduled within 30 days of discharge event. Limited to four (4) times per year.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

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.

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.

The in-network provider must be used for this service.

If you choose to utilize another provider, you are responsible for all charges.

Rewards and Incentives - Go365® by Humana

Complete eligible healthy activities, like preventive screenings and exams, and get rewarded with Go365 Advanced.

SilverSneakers® fitness program Live a healthier, more active life through fitness and social connection at

participating locations and online.

The in-network provider must be used for this service.

If you choose to utilize another provider, you are responsible for all charges.





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.

HumanaChoice - Diabetes and Heart (PPO C-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2026 based on a review of the HumanaChoice - Diabetes and Heart (PPO 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.

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

All product names, logos, brands and trademarks are property of their respective owners, and any use does not imply endorsement.

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 **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.

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. GHHNDN2025HUM

Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available. Call **877-320-1235 (TTY: 711)**.

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسيق البديل مجانًا. اتصل على الرقم 1235-320 877-320 (الهاتف النصى: 711).

Յայերեն [Armenian]։ Յասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ։ Չանգահարե՛ ք՝ **877-320-1235 (ТТҮ: 711)**։

বাংলা [Bengali]: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন 877-320-1235 (TTY: 711) নম্বরে।

简体中文 [Simplified Chinese]:我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 877-320-1235 (听障专线:711)。

繁體中文 [Traditional Chinese]:我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 877-320-1235 (聽障專線:711)。

Kreyòl Ayisyen [Haitian Creole]: Lang gratis, èd oksilyè, ak lòt fòma sèvis disponib. Rele **877-320-1235 (TTY: 711)**.

Hrvatski [Croatian]: Dostupni su besplatni jezik, dodatna pomoć i usluge alternativnog formata. Nazovite **877-320-1235 (TTY: 711)**.

فارسی [Farsi]: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با 1235-320-327 (TTY: 711) تماس بگیرید.

Français [French]: Des services gratuits linguistiques, d'aide auxiliaire et de mise au format sont disponibles. Appeler le **877-320-1235 (TTY: 711)**.

Deutsch [German]: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **877-320-1235 (TTY: 711)**.

Ελληνικά [Greek]: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **877-320-1235** (TTY: 711).

ગુજરાતી [Gujarati]: નિઃશુલ્ક ભાષા, સહ્યયક સહ્યય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **877-320-1235** (TTY: 711) પર કૉલ કરો.

עברית [Hebrew]: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **717: 711) 877-320-1235**

हिन्दी [Hindi]: निःशुल्क भाषा, सहायक मदद और वैकल्पिक प्रारूप सेवाएं उपलब्ध हैं। 877-320-1235 (TTY: 711) पर कॉल करें।

Hmoob [Hmong]: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **877-320-1235 (TTY: 711)**.

Italiano [Italian]: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiama il numero **877-320-1235 (TTY: 711)**.

This notice is available at https://www.humana.com/legal/multi-language-support Humana.

日本語 [Japanese]:言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。877-320-1235 (TTY: 711) までお電話ください。

ភាសាខ្មែរ[Khmer]៖ សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រងផ្សេងជំនួសអាចរកបាន។ ទូរសព្ទទៅ លេខ **877-320-1235 (TTY: 711)**។

한국어 [Korean]: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다. **877-320-1235 (TTY: 711)**번으로 문의하십시오.

ພາສາລາວ [Lao] ມີການບໍລິການດ້ານພາສາ, ອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ຮູບແບບທາງເລືອກອື່ນໃຫ້ໃຊ້ຟຣີ. ໂທ **877-320-1235 (TTY: 711)**.

Diné [Navajo]: Saad t'áá jiik'eh, t'áadoole'é binahji' bee adahodoonílígíí diné bich'i' anídahazt'i'í, dóó lahgo át'éego bee hada'dilyaaígíí bee bika'aanída'awo'í dahóló. Kohji' hodíilnih **877-320-1235 (TTY: 711)**.

Polski [Polish]: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **877-320-1235 (TTY: 711)**.

Português [Portuguese]: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **877-320-1235 (TTY: 711)**.

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫ਼ਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। **877-320-1235** (**TTY: 711)** 'ਤੇ ਕਾਲ ਕਰੋ।

Русский [Russian]: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **877-320-1235 (TTY: 711)**.

Español [Spanish]: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al **877-320-1235 (TTY: 711)**.

Tagalog [Tagalog]: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **877-320-1235 (TTY: 711)**.

தமிழ் [Tamil]: இலவச மொழி, துணை உதவி மற்றும் மாற்று வடிவ சேவைகள் உள்ளன. **877-320-1235 (TTY: 711)** ஐ அழைக்கவும்.

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు [పత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **877-320-1235 (TTY: 711)** కి కాల్ చేయండి.

اردو :[Urdu] مفت زبان، معاون امداد، اور متبادل فارمیث کی خدمات دستیاب ہیں۔ کال (TTY: 711) 320-1235 (TTY: 711)

Tiếng Việt [Vietnamese]: Có sẵn các dịch vụ miễn phí về ngôn ngữ, hỗ trợ bổ sung và định dạng thay thế. Hãy gọi **877-320-1235 (TTY: 711)**.

አማርኛ [Amharic]፦ ቋንቋ፣ አ*ጋ*ዥ ማዳሞጫ እና አማራጭ ቅርፀት ያላቸው *አገል* ማሎቶችም ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

Băsoó [Bassa]: Wudu-xwíníín-mú-zà-zà kằà, Hwòdŏ-fońo-ínyo, kè nyo-boằn-po-kà bě bé nyuεε se wídí péὲ-péὲ dò ko. 877-320-1235 (TTY: 711) dá.

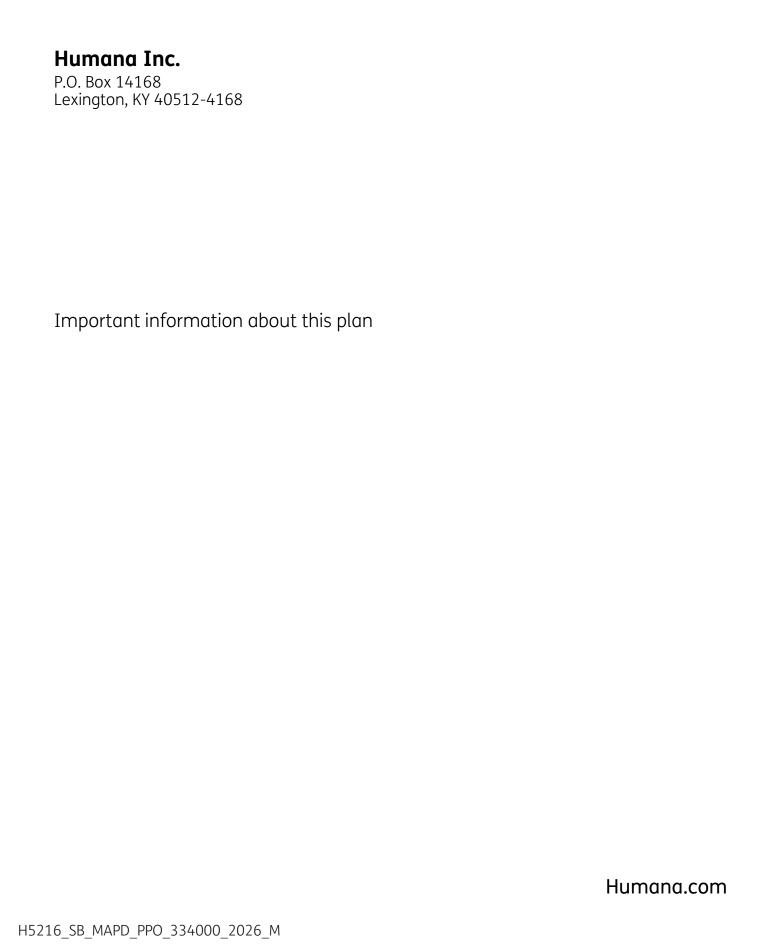
Bekee [Igbo]: Asusu n'efu, enyemaka nkwaru, na oru usoro ndi ozo di. Kpoo 877-320-1235 (TTY: 711).

Òyìnbó [Yoruba]: Àwọn işé àtìlẹhìn ìrànlówó èdè, àti ònà kíkà míràn wà lárowótó. Pe **877-320-1235 (TTY: 711)**.

नेपाली [Nepali]: भाषासम्बन्धी नि:शुल्क, सहायक साधन र वैकल्पिक फार्मेट (ढाँचा/व्यवस्था) सेवाहरू उपलब्ध छन् । 877-320-1235 (TTY: 711) मा कल गर्नुहोस् ।

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32