2024

Annual Notice of Changes

HumanaChoice
H5216-319 (PPO)
New Jersey

Humana®

Thank you for being a Humana member

Inside you'll find a comparison of your 2023 benefits to your 2024 benefits, along with more information about your 2024 plan coverage.

All 2024 Humana plans continue to cover preventive services like annual mammograms and prostate exams as well as no-cost vaccines—including the Shingles shot—to support your best health.

All 2024 Humana plans offer dental, vision and hearing coverage.

If you'd like to keep your current Humana plan, you don't need to do anything. It will automatically renew on Jan. 1, 2024.

Plan for the 2024 Medicare Advantage Annual Election Period

- **See how your plan is different.** Review this Annual Notice of Changes (ANOC) document for changes to your medical coverage, prescription drug coverage, in-network pharmacies, and costs like premium, copays, deductibles and coinsurance.
- **Know that this document doesn't include all your benefits.** The ANOC highlights plan changes but does not include a full list of your plan benefits. Starting October 15, see your 2024 Evidence of Coverage (EOC) at **Humana.com/PlanDocuments** for a complete listing. See the inside back panel of this document for more instructions.
- **Keep your current Humana member ID card.** Humana does not issue new ID cards each plan year for members choosing to remain on their current Humana Medicare plan. You will only receive a new ID card if the card's information changes or you select a different plan for 2024.

HumanaChoice H5216-319 (PPO) offered by Humana Insurance Company

Annual Notice of Changes for 2024

You are currently enrolled as a member of HumanaChoice H5216-342 (PPO). Next year, there will be changes to the plan's costs and benefits. ***Please see page 6 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at **Humana.com/PlanDocuments**. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2024 "Drug Guide" to make sure the drugs you currently take are still covered .

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

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

- If you don't join another plan by December 7, 2023, you will stay in HumanaChoice H5216-319 (PPO).
- To change to a **different plan** , you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024**. This will end your enrollment with HumanaChoice H5216-319 (PPO).
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.

OMB Approval 0938-1051 (Expires: February 29, 2024)

- Please contact our Customer Care number at 1-800-457-4708 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m. seven days a week from October 1 – March 31 and 8 a.m. to 8 p.m. Monday-Friday from April 1 - September 30.This call is free.

- This information is available in different formats, including braille, large print, and audio. Please call Customer Care at the number listed above if you need plan information in another format.

- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About HumanaChoice H5216-319 (PPO)

- HumanaChoice H5216-319 (PPO) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

- When this document says "we," "us," or "our", it means Humana Insurance Company. When it says "plan" or "our plan," it means HumanaChoice H5216-319 (PPO).

- Out-of-network/non-contracted providers are under no obligation to treat HumanaChoice H5216-319 (PPO) members, except in emergency situations. Please call our Customer Care number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

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Annual Notice of Changes for 2024
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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for HumanaChoice H5216-319 (PPO) in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)		2024 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Monthly plan premium* * Your premium may be higher than this amount. See Section 2.1 for details.	**$0**		**$0**	
Deductible	**$650** combined in-network and out-of-network except for insulin furnished through an item of durable medical equipment.	**$650** combined in-network and out-of-network except for insulin furnished through an item of durable medical equipment.	**$415** combined in-network and out-of-network except for insulin furnished through an item of durable medical equipment.	**$415** combined in-network and out-of-network except for insulin furnished through an item of durable medical equipment.
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	From network providers: **$8,300**	From network and out-of-network providers combined: **$12,450**	From network providers: **$7,550**	From network and out-of-network providers combined: **$11,000**
Doctor office visits	Primary care visits: **$0** copayment per visit Specialist visits: **$50** copayment per visit	Primary care visits: **30%** of the total cost per visit Specialist visits: **30%** of the total cost per visit	Primary care visits: **$0** copayment per visit Specialist visits: **$50** copayment per visit	Primary care visits: **30%** of the total cost per visit Specialist visits: **30%** of the total cost per visit
Inpatient hospital stays	**$390** copayment per day for days 1 – 4 **$0** copayment per day for days 5 – 90	**30%** of the total cost	**$340** copayment per day for days 1 – 7 **$0** copayment per day for days 8 – 90	**30%** of the total cost

Cost	2023 (this year)		2024 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: **$505** except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage:		Deductible: **$545** except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage:	
	For a 30-day supply from a **retail pharmacy**: • Drug Tier 1: **$0** • Drug Tier 2: **$5** • Drug Tier 3: **$47** You pay **$35** per month supply of each covered insulin on this tier. • Drug Tier 4: **$100** • Drug Tier 5: **25%** You pay **$35** per month supply of each covered insulin on this tier.		For a 30-day supply from a **retail pharmacy**: • Drug Tier 1: **$0** • Drug Tier 2: **$5** • Drug Tier 3: **$47** You pay **$35** per month supply of each covered insulin on this tier. • Drug Tier 4: **$100** • Drug Tier 5: **25%** You pay **$35** per month supply of each covered insulin on this tier.	
	For a 90-day supply from a **mail-order pharmacy** with preferred cost-sharing: • Drug Tier 1: **$0** • Drug Tier 2: **$0** • Drug Tier 3: **$131** You pay **$95** per 3-month supply of each covered insulin on this tier. • Drug Tier 4: **$290** • Drug Tier 5: Not available		For a 90-day supply from a **mail-order pharmacy** with preferred cost-sharing: • Drug Tier 1: **$0** • Drug Tier 2: **$0** • Drug Tier 3: **$131** You pay **$105** per 3-month supply of each covered insulin on this tier. • Drug Tier 4: **$290** • Drug Tier 5: Not available	

Cost	2023 (this year)		2024 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	For a 90-day supply from a **mail-order pharmacy** with standard cost-sharing: • Drug Tier 1: **$30** • Drug Tier 2: **$60** • Drug Tier 3: **$141** You pay **$105** per 3-month supply of each covered insulin on this tier. • Drug Tier 4: **$300** • Drug Tier 5: Not available		For a 90-day supply from a **mail-order pharmacy** with standard cost-sharing: • Drug Tier 1: **$30** • Drug Tier 2: **$60** • Drug Tier 3: **$141** You pay **$105** per 3-month supply of each covered insulin on this tier. • Drug Tier 4: **$300** • Drug Tier 5: Not available	
	Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called coinsurance), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs.)		Catastrophic Coverage: • During this payment stage, the plan pays the full cost of your covered Part D and excluded drugs. You pay nothing.	

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in HumanaChoice H5216-319 (PPO) in 2024

On January 1, 2024, Humana Insurance Company will be combining HumanaChoice H5216-342 (PPO) with one of our plans, HumanaChoice H5216-319 (PPO). The information in this document tells you about the differences between your current benefits in HumanaChoice H5216-342 (PPO) and the benefits you will have on January 1, 2024 as a member of HumanaChoice H5216-319 (PPO)

If you do nothing by December 7, 2023, we will automatically enroll you in our HumanaChoice H5216-319 (PPO). This means starting January 1, 2024, you will be getting your medical and prescription drug coverage through HumanaChoice H5216-319 (PPO). If you want to change plans or switch to Original Medicare, you must do so between October 15 and December 7. If you are eligible for "Extra Help", you may be able to change plans during other times.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 - Changes to the Monthly Premium

Cost	**2023** (this year)	**2024** (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	**$0** Your plan will reduce your monthly Medicare Part B premium by up to **$102**.	**$0** Your plan will reduce your monthly Medicare Part B premium by up to **$90**.
	The following will apply only if you have chosen or will choose to pay additional premium(s) to receive Optional Supplemental Benefits	
	MyOption DEN204 Not available	**MyOption DEN204** **$29.50 extra** monthly premium
	MyOption DEN205 Not available	**MyOption DEN205** **$42.30 extra** monthly premium
	MyOption DEN432 Not available	**MyOption DEN432** **$48.80 extra** monthly premium
	MyOption DEN478 **$28.40 extra** monthly premium	**MyOption DEN478** Not available

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

Section 2.2 - Changes to Your Maximum Out-of-Pocket Amounts

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

Cost	**2023** (this year)		**2024** (next year)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount. **Combined maximum out-of-pocket amount** Your costs for covered medical services (such as copays and deductibles) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	**$8,300**	**$12,450** combined in-network and out-of-network	**$7,550** Once you have paid **$7,550** out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.	**$11,000** combined in-network and out-of-network Once you have paid **$11,000** out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.

Section 2.3 - Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at **Humana.com/PlanDocuments**. You may also call Customer Care for updated provider and/or pharmacy information or to ask us to mail you a directory, *which we will mail within three business days.*

There are changes to our network of providers for next year. **Please review the 2024 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2024 *Provider Directory* to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Care so we may assist.

Section 2.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Services received at Rural Health Clinics, Federally Qualified Health Clinics, and Critical Access Hospitals may be subject to the Primary Care Physician or Specialist copay or coinsurance, as applicable, for 2024.

Cost	**2023** (this year)		**2024** (next year)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible exclusions	Not Applicable	The following services listed are excluded from the combined in-network and out-of-network deductible: In-Network only: Lab Services Primary Care Physician's Office Specialist's Office Both In-Network and Out-of-Network: Ambulance Services Chemotherapy Drugs and Administration Diabetic Monitoring Supplies Emergency Room Services Medicare Covered Preventive Services (including Immunizations (Flu & Pneumonia)) Medicare Part B Covered Drugs Services not covered by Original Medicare	Not Applicable	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 Diabetic Monitoring Supplies Diagnostic Colonoscopy Diagnostic Mammography Lab Services Medicare Part B Covered Drugs Primary Care Physician's Office Specialist's Office Both In-Network and Out-of-Network: Emergency Room Services Medicare Covered Preventive Services (including Immunizations (Flu & Pneumonia))

Cost	2023 (this year)		2024 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
		Urgently Needed Services at Urgent Care Centers		Services not covered by Original Medicare Urgently Needed Services at Urgent Care Centers
Ambulance services				
• For each Medicare-covered emergency transportation by ground, you pay:	**$290** copayment per date of service	**$290** copayment per date of service	**$300** copayment per date of service	**$300** copayment per date of service
• For each Medicare-covered emergency transportation by air, you pay:	**$290** copayment per date of service	**$290** copayment per date of service	**$300** copayment per date of service	**$300** copayment per date of service
• For each Medicare-covered non-emergency transportation by ground, you pay:	**$290** copayment per date of service	**$290** copayment per date of service	**$300** copayment per date of service	**$300** copayment per date of service
• For each Medicare-covered non-emergency transportation by air, you pay:	**$290** copayment per date of service	**$290** copayment per date of service	**$300** copayment per date of service	**$300** copayment per date of service
Chiropractic services				
• For each Medicare-covered visit (manual manipulation of the spine to correct subluxation), you pay:				
– at a specialist's office	**$20** copayment	**30%** of the total cost	**$15** copayment	No Change
• For each routine visit	**$0** copayment for routine chiropractic visits up to unlimited visit(s) per year.	**$0** copayment for routine chiropractic visits up to unlimited visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums,	**$15** copayment for routine chiropractic visits up to 12 visit(s) per year.	**$15** copayment 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.

Cost	2023 (this year)		2024 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
		limitations, and/or exclusions.		
Dental services • Supplemental dental benefits:	**DEN355** **0%** coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. **0%** coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years. **0%** coinsurance for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. **0%** coinsurance for emergency diagnostic exam up to 1 per year. **0%** coinsurance for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. **0%** coinsurance for periodontal maintenance up to 4 per year. **0%** coinsurance for necessary anesthesia with covered service up to unlimited per year. **$25** copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. **$25** copayment for scaling for	**DEN355** **0%** coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. **0%** coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years. **0%** coinsurance for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. **0%** coinsurance for emergency diagnostic exam up to 1 per year. **0%** coinsurance for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. **0%** coinsurance for periodontal maintenance up to 4 per year. **0%** coinsurance for necessary anesthesia with covered service up to unlimited per year. **$25** copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. **$25** copayment for scaling for	**DEN350** **$0** copayment for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. **$0** copayment for panoramic film or diagnostic x-rays up to 1 every 5 years. **$0** copayment for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. **$0** copayment for emergency diagnostic exam up to 1 per year. **$0** copayment for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. **$0** copayment for periodontal maintenance up to 4 per year. **$0** copayment for necessary anesthesia with covered service up to unlimited per year.	**DEN350** **$0** copayment for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. **$0** copayment for panoramic film or diagnostic x-rays up to 1 every 5 years. **$0** copayment for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. **$0** copayment for emergency diagnostic exam up to 1 per year. **$0** copayment for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. **$0** copayment for periodontal maintenance up to 4 per year. **$0** copayment for necessary anesthesia with covered service up to unlimited per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Cost	2023 (this year)		2024 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	moderate inflammation up to 1 every 3 years. **$25** copayment for crown recementation, bridge recementation up to 1 every 5 years. **$25** copayment for emergency treatment for pain up to 2 per year. **$25** copayment per tooth for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year. **50%** coinsurance for occlusal adjustment up to 1 every 3 years. **50%** coinsurance for bridges up to 1 every 5 years. **50%** coinsurance for crown, root canal, root canal retreatment up to 1 per tooth per lifetime. **50%** coinsurance for oral surgery up to 2 per year. **$1,000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits.	moderate inflammation up to 1 every 3 years. **$25** copayment for crown recementation, bridge recementation up to 1 every 5 years. **$25** copayment for emergency treatment for pain up to 2 per year. **$25** copayment per tooth for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year. **50%** coinsurance for occlusal adjustment up to 1 every 3 years. **50%** coinsurance for bridges up to 1 every 5 years. **50%** coinsurance for crown, root canal, root canal retreatment up to 1 per tooth per lifetime. **50%** coinsurance for oral surgery up to 2 per year. **$1,000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits. Benefits received out-of-network are subject to any in-network benefit maximums,		

Cost	2023 (this year)		2024 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
		limitations, and/or exclusions.		
Diabetes self-management training, diabetic services and supplies • For each Medicare-covered diabetic supply item, you pay: – at a diabetic supplier	**20%** of the total cost	**30%** of the total cost	**10%** of the total cost	No Change
Emergency care • For each Medicare-covered emergency room visit, you pay:	**$95** copayment waived if admitted within 24 hours When placed in observation, member pays observation cost-share instead of emergency room cost-share.	**$95** copayment waived if admitted within 24 hours When placed in observation, member pays observation cost-share instead of emergency room cost-share.	**$100** copayment waived if admitted within 24 hours When placed in observation, member pays observation cost-share instead of emergency room cost-share.	**$100** copayment waived if admitted within 24 hours When placed in observation, member pays observation cost-share instead of emergency room cost-share.
Inpatient hospital care • For a Medicare-covered stay at a hospital, you pay:	**$390** copayment per day for days 1 - 4 **$0** copayment per day for days 5 - 90	**30%** of the total cost	**$340** copayment per day for days 1 - 7 **$0** copayment per day for days 8 - 90	No Change
Inpatient mental health care • For a Medicare-covered stay at a hospital, you pay:	**$390** copayment per day for days 1 - 4 **$0** copayment per day for days 5 - 90	**30%** of the total cost	**$340** copayment per day for days 1 - 7 **$0** copayment per day for days 8 - 90	No Change
• For a Medicare-covered stay at an inpatient psychiatric facility, you pay:	**$390** copayment per day for days 1 - 4 **$0** copayment per day for days 5 - 90	**30%** of the total cost	**$275** copayment per day for days 1 - 7 **$0** copayment per day for days 8 - 90	No Change
Opioid treatment program services • For each Medicare-covered opioid				

Cost	**2023** (this year)		**2024** (next year)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
treatment services visit, you pay:				
– at a hospital facility as an outpatient	**$90** copayment	**30%** of the total cost	**$100** copayment	No Change
Outpatient diagnostic tests, therapeutic services and supplies				
• For diagnostic procedures and tests, you pay:				
– at an urgent care center	**$40** copayment	**30%** of the total cost	**$55** copayment	**$55** copayment
• For advanced imaging services (MRI, MRA, PET, or CT Scan), you pay:				
– at your primary care provider's office	**$180** copayment	**30%** of the total cost	**$200** copayment	No Change
– at a specialist's office	**$180** copayment	**30%** of the total cost	**$200** copayment	No Change
– at a freestanding radiology facility	**$180** copayment	**30%** of the total cost	**$200** copayment	No Change
– at a hospital facility as an outpatient	**$275** copayment	**30%** of the total cost	**$300** copayment	No Change
• For basic radiological services, you pay:				
– at a hospital facility as an outpatient	**$110** copayment	**30%** of the total cost	**$125** copayment	No Change
– at an urgent care center	**$40** copayment	**30%** of the total cost	**$55** copayment	**$55** copayment
• For medical supplies, you pay:	**17%** of the total cost	**30%** of the total cost	**10%** of the total cost	No Change
• For lab services, you pay:				
– at an urgent care center	**$40** copayment	**30%** of the total cost	**$55** copayment	**$55** copayment
Outpatient hospital observation				
• For each Medicare-covered observation services visit, you pay:				
– at a hospital facility as an outpatient	**$350** copayment	**30%** of the total cost	**$340** copayment	**$340** copayment

Cost	**2023** (this year)		**2024** (next year)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Outpatient mental health care • For each Medicare-covered individual/group therapy visit, you pay: – at a hospital facility as an outpatient	**$90** copayment	**30%** of the total cost	**$100** copayment	No Change
Outpatient substance abuse services • For each Medicare-covered individual/group therapy visit, you pay: – at a hospital facility as an outpatient	**$90** copayment	**30%** of the total cost	**$100** copayment	No Change
Podiatry services • For each routine visit	**$0** copayment for routine podiatry visits up to 12 visit(s) per year.	**$0** copayment for routine podiatry 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.	**$40** copayment for routine podiatry visits up to unlimited visit(s) per year.	**$65** copayment for routine podiatry visits up to unlimited visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
SilverSneakers® fitness program	Covered	Not Covered	Not Covered	Not Covered
Skilled nursing facility (SNF) care • For a Medicare-covered stay at a skilled nursing facility, you pay:	**$0** copayment per day for days 1 - 20 **$196** copayment per day for days 21 - 100	**30%** of the total cost for days 1 - 100	**$0** copayment per day for days 1 - 20 **$203** copayment per day for days 21 - 100	No Change
Urgently needed services • For Medicare-covered urgently needed services, you pay:				

Cost	2023 (this year)		2024 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
– at an urgent care center	**$40** copayment	**$40** copayment	**$55** copayment	**$55** copayment
– for an urgent care-virtual visit	**$0** copayment	Not Applicable	**$55** copayment	Not Applicable
Vision care				
• Routine vision services:	**VIS751** **$0** copayment for routine exam up to 1 per year. **$75** combined maximum benefit coverage amount per year for routine exam. **$100** 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.	**VIS751** **$0** copayment for routine exam up to 1 per year. **$75** combined maximum benefit coverage amount per year for routine exam. **$100** 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.	**VIS694** **$0** copayment for routine exam up to 1 per year. **$75** combined maximum benefit coverage amount per year for routine exam. **$50** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. **$100** 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.	**VIS694** **$0** copayment for routine exam up to 1 per year. **$75** combined maximum benefit coverage amount per year for routine exam. **$50** 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.
Worldwide coverage				

Cost	**2023** (this year)		**2024** (next year)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
• For each emergency room visit, you pay:	Not Applicable	**$95** copayment waived if admitted within 24 hours	Not Applicable	**$100** copayment waived if admitted within 24 hours

Optional Supplemental Benefits (OSB)
If you choose to pay an extra premium, you can get these benefits. When applicable enrollees must continue to pay the Medicare Part B premium, their Humana plan premium, and the OSB premium.

Cost **2023** (this year)		**2024** (next year)	
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
MyOption DEN204 • **Not available with your plan**		**MyOption DEN204** • **$29.50 extra** monthly premium • No deductible • **$2,000** maximum allowed benefit	
		0% coinsurance or **$25** copayment for basic services **50%** coinsurance or **$25** copayment for major services	**0%** coinsurance or **$25** copayment for basic services **50%** coinsurance or **$25** copayment for major services Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
MyOption DEN205 • **Not available with your plan**		**MyOption DEN205** • **$42.30 extra** monthly premium • No deductible • **$2,000** maximum allowed benefit	
		0% coinsurance or **$25** copayment for basic services **0%–50%** coinsurance for major services *(includes denture coverage)*	**0%** coinsurance or **$25** copayment for basic services **0%–50%** coinsurance for major services *(includes denture coverage)* Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
MyOption DEN432 • **Not available with your plan**		**MyOption DEN432** • **$48.80 extra** monthly premium • No deductible • **$2,000** maximum allowed benefit	

Cost	**2023** (this year)	**2024** (next year)	
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
		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 cosmetic services and implants.	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 cosmetic services and implants. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

<table>
<tr><th>Cost</th><th colspan="2">2023 (this year)</th><th colspan="2">2024 (next year)</th></tr>
<tr><th>In-Network</th><th>Out-of-Network</th><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td colspan="2">MyOption DEN478

• $28.40 extra monthly premium
• No deductible
• $2,000 maximum allowed benefit</td><td colspan="2" rowspan="2">MyOption DEN478

• Not available with your 2024 plan. If you would like to explore OSB options for 2024, please contact your agent at this time or call OSB sales on or after December 8, 2023 at 888-413-7026.</td></tr>
<tr><td>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 cosmetic services and implants.</td><td>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 cosmetic services and implants.

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

Section 2.5 - Changes to Part D Prescription Drug Coverage

Changes to Our "Drug Guide"

Our list of covered drugs is called a Formulary or "Drug Guide." A copy of our "Drug Guide" is provided electronically. **You can also get the "Drug Guide"** by calling Customer Care (see the back cover) or visiting our website (**Humana.com/PlanDocuments**).

We made changes to our "Drug Guide," which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the "Drug Guide" to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier**.

Most of the changes in the "Drug Guide" are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online "Drug Guide" to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Customer Care for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you**. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30, please call Customer Care and ask for the LIS Rider.

There are four **drug payment stages**. The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage).

Changes to the Deductible Stage

Stage	**2023** (this year)	**2024** (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3, Tier 4, and Tier 5 drugs until you have reached the yearly deductible. The deductible does not apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.	The deductible is **$505**. During this stage, you pay **$0** cost-sharing for drugs on Tier 1, **$5** cost-sharing for drugs on Tier 2 and the full cost of drugs on Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible.	The deductible is **$545**. During this stage, you pay **$0** cost-sharing for drugs on Tier 1, **$5** cost-sharing for drugs on Tier 2 and the full cost of drugs on Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	**2023** (this year)	**2024** (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The cost in these rows are for a one-month (up to a 30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our "Drug Guide". To see if your drugs will be in a different tier, look them up on the "Drug Guide". Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month (up to a 30-day) supply at a retail network pharmacy:	Your cost for a one-month (up to a 30-day) supply at a retail network pharmacy:
	Preferred Generic: You pay **$0** per prescription.	**Preferred Generic:** You pay **$0** per prescription.
	Generic: You pay **$5** per prescription.	**Generic:** You pay **$5** per prescription.
	Preferred Brand: You pay **$47** per prescription. You pay **$35** per month supply of each covered insulin on this tier.	**Preferred Brand:** You pay **$47** per prescription. You pay **$35** per month supply of each covered insulin on this tier.
	Non-Preferred Drug: You pay **$100** per prescription.	**Non-Preferred Drug:** You pay **$100** per prescription.
	Specialty Tier: You pay **25%** per prescription. You pay **$35** per month supply of each covered insulin on this tier.	**Specialty Tier:** You pay **25%** per prescription. You pay **$35** per month supply of each covered insulin on this tier.
	Once your total drug costs have reached **$4,660**, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached **$5,030**, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.**

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 - If you want to stay in HumanaChoice H5216-319 (PPO)

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our plan HumanaChoice H5216-319 (PPO).

Section 3.2 - If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (SHIP) (see Section 5), or call Medicare (see Section 7.2).

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from HumanaChoice H5216-319 (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from HumanaChoice H5216-319 (PPO).
- To **change to Original Medicare without a prescription drug plan,** you must either:

- Send us a written request to disenroll or visit our website to disenroll online. Contact Customer Care if you need more information on how to do so.
- *– Or –* Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2024.

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

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2024, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2024.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. State Health Insurance Assistance Program (SHIP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call your State Health Insurance Assistance Program at the number listed in "Exhibit A" in the back of this document.

SECTION 6 Programs That Help Pay for Prescription Drugs

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

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;

- The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
- Your State Medicaid Office (applications).

- **Help from your state's pharmaceutical assistance program.** Many states have State Pharmaceutical Assistance Programs (SPAPs) that help people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in "Exhibit A" of this document).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the ADAP program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP program (the name and phone numbers for this organization are in "Exhibit A" in the back of this document).

SECTION 7 Questions?

Section 7.1 - Getting Help from HumanaChoice H5216-319 (PPO)

Questions? We're here to help. Please call Customer Care at 1-800-457-4708. (TTY only, call 711.) We are available for phone calls from 8 a.m. to 8 p.m. seven days a week from Oct. 1 – Mar. 31 and 8 a.m. to 8 p.m. Monday-Friday from Apr. 1 - Sept. 30. Calls to these numbers are free.

Read your *2024 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2024. For details, look in the 2024 *Evidence of Coverage* for HumanaChoice H5216-319 (PPO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at **Humana.com/PlanDocuments**.You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at **Humana.com/PlanDocuments**. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *list of covered drugs (Formulary/"Drug Guide")*.

Section 7.2 - Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

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

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Exhibit A- State Agency Contact Information

This section provides the contact information for the state agencies referenced in this Annual Notice of Changes. If you have trouble locating the information you seek, please contact Customer Care at the phone number on the back cover of this booklet.

NEW JERSEY	
SHIP Name and Contact Information	State Health Insurance Assistance Program (SHIP) P.O. Box 715 Trenton, NJ 08625-0715 1-800-792-8820 (toll free) 1-877-222-3737 http://www.state.nj.us/humanservices/doas/services/ship/index.html
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-866-815-5440 1-866-868-2289 (TTY) 1-855-236-2423 (Fax) https://livantaqio.com/
State Medicaid Office	NH Family Care P.O. Box 712 Trenton, NJ 08625-0712 1-800-356-1561 (toll free) 1-877-294-4356 (TTY) http://www.state.nj.us/humanservices/dmahs
State Pharmacy Assistance Program(s)	New Jersey Senior Gold Prescription Discount Program New Jersey Department of Health and Senior Services Senior Gold Discount Program P.O. Box 715 Trenton, NJ 08625 1-800-792-9745 (toll free) http://www.state.nj.us/humanservices/doas/services/seniorgold/
AIDS Drug Assistance Program	AIDS Drug Distribution Program (ADDP) New Jersey ADDP Office PO Box 722 Trenton, NJ 08625 1-877-613-4533 1-609-588-7037 (fax) https://www.nj.gov/health/hivstdtb/hiv-aids/medica

Insurance ACE
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your personal and health information is important. You do not need to do anything unless you have a request or complaint.

This Notice of Privacy Practices applies to all entities that are part of the Insurance ACE, an Affiliated Covered Entity under HIPAA. The ACE is a group of legally separate covered entities that are affiliated and have designated themselves as a single covered entity for purposes of HIPAA. A complete list of the members of the ACE is available at https://huma.na/insuranceace

We may change our privacy practices and the terms of this notice at any time, as allowed by law, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is nonpublic personal or health information?
Nonpublic personal or health information includes both medical information and personal information, like your name, address, telephone number, Social Security number, account numbers, payment information, or demographic information. The term "information" in this notice includes any nonpublic personal and health information. This includes information created or received by a healthcare provider or health plan. The information relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare.

How do we collect information about you?
We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

What information do we receive about you?
The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

How do we protect your information?
We have a responsibility to protect the privacy of your information in all formats including electronic, and oral information. We have administrative, technical, and physical safeguards in place to protect your information in various ways including:
- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our employees about our privacy program and procedures

How do we use and disclose your information?
We use and disclose your information:
- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services

We have the right to use and disclose your information:
- To a doctor, a hospital, or other healthcare provider so you can receive medical care.

- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments.
- For healthcare operation activities, including processing your enrollment, responding to your inquiries, coordinating your care, improving quality, and determining premiums.
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform, plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations. For example, to allow your plan sponsor to obtain bids from other health plans. Your detailed health information will not be shared with your plan sponsor. We will ask your permission, or your plan sponsor must certify they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or treatment alternatives that may be of interest to you. If you have opted out, we will not contact you.
- To your family and friends if you are unavailable to communicate, such as in an emergency.
- To your family and friends, or any other person you identify. This applies if the information is directly relevant to their involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm if the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation.
- To public health agencies, if we believe that there is a serious health or safety threat.
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence.
- In response to a court or administrative order, subpoena, discovery request, or other lawful process.
- For law enforcement purposes, to military authorities and as otherwise required by law.
- To help with disaster relief efforts.
- For compliance programs and health oversight activities.
- To fulfill our obligations under any workers' compensation law or contract.
- To avert a serious and imminent threat to your health or safety or the health or safety of others.
- For research purposes in limited circumstances and provided that they have taken appropriate measures to protect your privacy.
- For procurement, banking, or transplantation of organs, eyes, or tissue.
- To a coroner, medical examiner, or funeral director.

Will we use your information for purposes not described in this notice?
We will not use or disclose your information for any reason that is not described in this notice, without your written permission. You may cancel your permission at any time by notifying us in writing.
The following uses and disclosures will require your written permission:
- Most uses and disclosures of psychotherapy notes
- Marketing purposes
- Sale of personal and health information

What do we do with your information when you are no longer a member?
Your information may continue to be used for purposes described in this notice. This includes when you do not obtain coverage through us. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?
We are committed to responding to your rights request in a timely manner
- Access - You have the right to review and obtain a copy of your information that may be used to make decisions about you. You also may receive a summary of this health information. As required under applicable law, we will make this personal information available to you or to your designated representative.
- Adverse Underwriting Decision - If we decline your application for insurance, you have the right to be provided a reason for the denial.
- Alternate Communications - To avoid a life- threatening situation, you have the right to receive your information in a different manner or at a different place. We will accommodate your request if it is reasonable.
- Amendment - You have the right to request correction of any of this personal information through amendment

or deletion. Within 60 business days of receipt of your written request, we will notify you of our amendment or deletion of the information in dispute, or of our refusal to make such correction after further investigation. If we refuse to amend or delete the information in dispute, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the information in dispute and what you consider to be the correct information. We shall make such a statement accessible to any and all parties reviewing the information in dispute.*

- Disclosure - You have the right to receive a listing of instances in which we or our business associates have disclosed your information. This does not apply to treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee.
- Notice - You have the right to request and receive a written copy of this notice any time.
- Restriction - You have the right to ask to limit how your information is used or disclosed. We are not required to agree to the limit, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted limitation.

* This right applies only to our Massachusetts residents in accordance with state regulations.

If I believe that my privacy has been violated, what should I do?
If you believe that your privacy has been violated you may file a complaint with us by calling us at 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You can also e-mail your complaint to OCRComplaint@hhs.gov. If you elect to file a complaint, your benefits will not be affected and we will not punish or retaliate against you in any way.

We support your right to protect the privacy of your personal and health information.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

We can change the terms of this notice, and the changes will apply to all information we have about you.

The new notice will be available upon request, in our office, and on our web site.

How do I exercise my rights or obtain a copy of this notice?
All of your privacy rights can be exercised by obtaining the applicable forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762
- Accessing our Website at **Humana.com** and going to the Privacy Practices link
- Send completed request form to:

Humana Inc.
Privacy Office 003/10911
101 E. Main Street
Louisville, KY 40202

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 the 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.

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 .

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。

Notes

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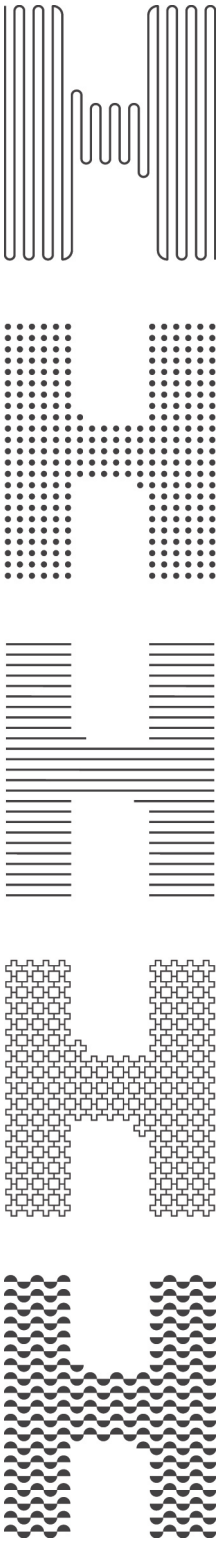

Starting October 15, 2023, you can view and search these 2024 plan documents at **Humana.com/PlanDocuments**. Here you can see the most up-to-date information about your plan. It's easy to search, so you can find the information you are looking for quickly.

- See your Evidence of Coverage for your plan's specific details, benefits and costs.
- View the provider directory to see a list of providers and specialists in your plan's network.
- Drug list: list of drugs covered in your plan

We're here for you. If you need help using these online tools, please call the number on the back of your Humana member ID card for support.

To get paper copies of these documents by mail, submit your request 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" and/or "provider directory." Please allow up to two weeks to receive the documents by mail.

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.

Humana Inc.
PO Box 14168
Lexington, KY 40512-4168

H5216342000319000ANOC24

Important information about changes to your Medicare Advantage and prescription drug plan

Look inside

Here's a summary of your **HumanaChoice H5216-319 (PPO)** that takes effect on January 1, 2024.

Humana®

Humana.com
1-800-457-4708 (TTY: 711)