

2024

# Annual Notice of Changes

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**Humana Gold Plus**  
**H6622-001 (HMO)**  
Milwaukee/Green Bay  
Green Bay area

**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](https://www.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.

## Annual Notice of Changes for 2024

You are currently enrolled as a member of Humana Gold Plus H6622-034 (HMO). 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](https://www.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.**
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### 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](https://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 Humana Gold Plus H6622-001 (HMO).
- 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 Humana Gold Plus H6622-001 (HMO).
- 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.

- 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](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information.

### **About Humana Gold Plus H6622-001 (HMO)**

- Humana Gold Plus H6622-001 (HMO) is a Medicare Advantage HMO 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 WI Health Organization Insurance Corp. When it says "plan" or "our plan," it means Humana Gold Plus H6622-001 (HMO).
- Out-of-network/non-contracted providers are under no obligation to treat Humana Gold Plus H6622-001 (HMO) 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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Lists the names, addresses, phone numbers, and other contact information for a variety of helpful resources in your state.

Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for Humana Gold Plus H6622-001 (HMO) in several important areas. **Please note this is only a summary of costs.**

| Cost                                                                                                                                                                      | 2023 (this year)                                                                                                                                      | 2024 (next year)                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                           | In-Network                                                                                                                                            | In-Network                                                                                            |
| <b>Monthly plan premium*</b><br><br>* Your premium may be higher than this amount. See Section 2.1 for details.                                                           | \$0                                                                                                                                                   | \$0                                                                                                   |
| <b>Maximum out-of-pocket amount</b><br><br>This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.) | \$3,500                                                                                                                                               | \$3,850                                                                                               |
| <b>Doctor office visits</b>                                                                                                                                               | Primary care visits:<br>\$0 copayment per visit<br><br>Specialist visits:<br>\$35 copayment per visit                                                 | Primary care visits:<br>\$0 copayment per visit<br><br>Specialist visits:<br>\$35 copayment per visit |
| <b>Inpatient hospital stays</b>                                                                                                                                           | \$250 copayment per day for days 1 – 5<br><br>\$0 copayment per day for days 6 – 90                                                                   | \$275 copayment per day for days 1 – 6<br><br>\$0 copayment per day for days 7 – 90                   |
| <b>Part D prescription drug coverage</b><br>(See Section 2.5 for details.)                                                                                                | Deductible: \$200 except for covered insulin products and most adult Part D vaccines.<br><br>Copayment/Coinsurance during the Initial Coverage Stage: | Deductible: \$0<br><br>Copayment/Coinsurance during the Initial Coverage Stage:                       |

| Cost | 2023 (this year)                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2024 (next year)                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|      | In-Network                                                                                                                                                                                                                                                                                                                                                                                                                                         | In-Network                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|      | <p>For a 30-day supply from a <b>retail pharmacy</b>:</p> <ul style="list-style-type: none"> <li>• Drug Tier 1: <b>\$0</b></li> <li>• Drug Tier 2: <b>\$0</b></li> <li>• Drug Tier 3: <b>\$47</b><br/>You pay <b>\$35</b> per month supply of each covered insulin on this tier.</li> <li>• Drug Tier 4: <b>\$100</b></li> <li>• Drug Tier 5: <b>29%</b><br/>You pay <b>\$35</b> per month supply of each covered insulin on this tier.</li> </ul> | <p>For a 30-day supply from a <b>retail pharmacy</b>:</p> <ul style="list-style-type: none"> <li>• Drug Tier 1: <b>\$0</b></li> <li>• Drug Tier 2: <b>\$5</b></li> <li>• Drug Tier 3: <b>\$47</b><br/>You pay <b>\$35</b> per month supply of each covered insulin on this tier.</li> <li>• Drug Tier 4: <b>\$100</b></li> <li>• Drug Tier 5: <b>33%</b><br/>You pay <b>\$35</b> per month supply of each covered insulin on this tier.</li> </ul> |
|      | <p>For a 90-day supply from a <b>mail-order pharmacy</b> with preferred cost-sharing:</p> <ul style="list-style-type: none"> <li>• Drug Tier 1: <b>\$0</b></li> <li>• Drug Tier 2: <b>\$0</b></li> <li>• Drug Tier 3: <b>\$131</b><br/>You pay <b>\$95</b> per 3-month supply of each covered insulin on this tier.</li> <li>• Drug Tier 4: <b>\$290</b></li> <li>• Drug Tier 5: Not available</li> </ul>                                          | <p>For a 90-day supply from a <b>mail-order pharmacy</b> with preferred cost-sharing:</p> <ul style="list-style-type: none"> <li>• Drug Tier 1: <b>\$0</b></li> <li>• Drug Tier 2: <b>\$0</b></li> <li>• Drug Tier 3: <b>\$131</b><br/>You pay <b>\$105</b> per 3-month supply of each covered insulin on this tier.</li> <li>• Drug Tier 4: <b>\$290</b></li> <li>• Drug Tier 5: Not available</li> </ul>                                         |
|      | <p>For a 90-day supply from a <b>mail-order pharmacy</b> with standard cost-sharing:</p> <ul style="list-style-type: none"> <li>• Drug Tier 1: <b>\$30</b></li> <li>• Drug Tier 2: <b>\$60</b></li> <li>• Drug Tier 3: <b>\$141</b><br/>You pay <b>\$105</b> per 3-month supply of each covered insulin on this tier.</li> <li>• Drug Tier 4: <b>\$300</b></li> <li>• Drug Tier 5: Not available</li> </ul>                                        | <p>For a 90-day supply from a <b>mail-order pharmacy</b> with standard cost-sharing:</p> <ul style="list-style-type: none"> <li>• Drug Tier 1: <b>\$30</b></li> <li>• Drug Tier 2: <b>\$60</b></li> <li>• Drug Tier 3: <b>\$141</b><br/>You pay <b>\$105</b> per 3-month supply of each covered insulin on this tier.</li> <li>• Drug Tier 4: <b>\$300</b></li> <li>• Drug Tier 5: Not available</li> </ul>                                        |

| Cost | 2023 (this year)                                                                                                                                                                                                                                                                                                                                                                                                                          | 2024 (next year)                                                                                                                                                                                    |
|------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|      | In-Network                                                                                                                                                                                                                                                                                                                                                                                                                                | In-Network                                                                                                                                                                                          |
|      | <div>Catastrophic Coverage:<ul style="list-style-type: none"><li>During this payment stage, the plan pays most of the cost for your covered drugs.</li><li>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.)</li></ul></div> | <div>Catastrophic Coverage:<ul style="list-style-type: none"><li>During this payment stage, the plan pays the full cost of your covered Part D and excluded drugs. You pay nothing.</li></ul></div> |



SECTION 1

Unless You Choose Another Plan, You Will Be Automatically Enrolled in Humana Gold Plus H6622-001 (HMO) in 2024

On January 1, 2024, Humana WI Health Organization Insurance Corp will be combining Humana Gold Plus H6622-034 (HMO) with one of our plans, Humana Gold Plus H6622-001 (HMO). The information in this document tells you about the differences between your current benefits in Humana Gold Plus H6622-034 (HMO) and the benefits you will have on January 1, 2024 as a member of Humana Gold Plus H6622-001 (HMO).

**If you do nothing by December 7, 2023, we will automatically enroll you in our Humana Gold Plus H6622-001 (HMO).** This means starting January 1, 2024, you will be getting your medical and prescription drug coverage through Humana Gold Plus H6622-001 (HMO). 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<br>(You must also continue to pay your Medicare Part B premium.) | \$0                                                                                                                                    | \$0                                                     |
|                                                                                  | The following will apply only if you have chosen or will choose to pay additional premium(s) to receive Optional Supplemental Benefits |                                                         |
|                                                                                  | <b>MyOption DEN478</b><br>\$39.90 extra monthly premium                                                                                | <b>MyOption DEN478</b><br>\$43.70 extra monthly premium |

- 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 Amount

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. This limit is called the maximum out-of-pocket amount. 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       | In-Network                                                                                                                                                                                                    |
| <b>Maximum out-of-pocket amount</b><br>Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount. | <b>\$3,500</b>   | <b>\$3,850</b><br>Once you have paid <b>\$3,850</b> out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services 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                                                                               | In-Network                                                                               |
| <b>Ambulance services</b> <ul style="list-style-type: none"> <li>For each Medicare-covered emergency transportation by ground, you pay:</li> <li>For each Medicare-covered non-emergency transportation by ground, you pay:</li> </ul> | <b>\$290</b> copayment per date of service<br><b>\$290</b> copayment per date of service | <b>\$300</b> copayment per date of service<br><b>\$300</b> copayment per date of service |
| <b>Cardiac rehabilitation services</b> <ul style="list-style-type: none"> <li>at a specialist's office</li> </ul>                                                                                                                      | <b>\$30</b> copayment                                                                    | <b>\$0</b> copayment                                                                     |

| Cost                                                                                                                                                                                                                                                             | 2023 (this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2024 (next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                  | In-Network                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | In-Network                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| – at a hospital facility as an outpatient                                                                                                                                                                                                                        | <b>\$30</b> copayment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>\$0</b> copayment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Chiropractic services</b> <ul style="list-style-type: none"> <li>For each Medicare-covered visit (manual manipulation of the spine to correct subluxation), you pay: <ul style="list-style-type: none"> <li>– at a specialist's office</li> </ul> </li> </ul> | <b>\$0</b> copayment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>\$20</b> copayment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Dental services</b> <ul style="list-style-type: none"> <li>Supplemental dental benefits:</li> </ul>                                                                                                                                                           | <b>DEN280</b><br><b>\$0</b> copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.<br><b>\$0</b> copayment for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years.<br><b>\$0</b> copayment for complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years.<br><b>\$0</b> copayment for crown, root canal, root canal retreatment up to 1 per tooth per lifetime.<br><b>\$0</b> copayment for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.<br><b>\$0</b> copayment for adjustments to dentures, denture rebase, denture relines, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year.<br><b>\$0</b> copayment for emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.<br><b>\$0</b> copayment for periodontal maintenance up to 4 per year.<br><b>\$0</b> copayment for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. | <b>DEN278</b><br><b>\$0</b> copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.<br><b>\$0</b> copayment for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years.<br><b>\$0</b> copayment for complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years.<br><b>\$0</b> copayment for crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime.<br><b>\$0</b> copayment for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.<br><b>\$0</b> copayment for adjustments to dentures, denture rebase, denture relines, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year.<br><b>\$0</b> copayment for emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.<br><b>\$0</b> copayment for periodontal maintenance up to 4 per year.<br><b>\$0</b> copayment for amalgam and/or composite filling, necessary anesthesia with |

| Cost                                                                                                                                      | 2023 (this year)                                                                                                                                                                                                    | 2024 (next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                           | In-Network                                                                                                                                                                                                          | In-Network                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                           | <b>\$2,000</b> maximum benefit coverage amount per year for all preventive and comprehensive benefits.                                                                                                              | covered service, simple or surgical extraction up to unlimited per year.<br><b>\$1,500</b> maximum benefit coverage amount per year for all preventive and comprehensive benefits.                                                                                                                                                                                                                                                                                                                               |
| <b>Emergency care</b> <ul style="list-style-type: none"> <li>For each Medicare-covered emergency room visit, you pay:</li> </ul>          | <b>\$90</b> copayment waived if admitted within 24 hours                                                                                                                                                            | <b>\$135</b> copayment waived if admitted within 24 hours<br>When placed in observation, member pays observation cost-share instead of emergency room cost-share.                                                                                                                                                                                                                                                                                                                                                |
| <b>Hearing services</b> <ul style="list-style-type: none"> <li>Supplemental hearing benefits:</li> </ul>                                  | <b>HER905</b><br><b>\$0</b> copayment for fitting/evaluation, routine hearing exams up to 1 per year.<br><b>\$750</b> maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year. | <b>HER955</b><br><b>\$0</b> copayment for routine hearing exams up to 1 per year.<br><b>\$0</b> copayment for follow-up provider visits up to unlimited per year.<br><b>\$299</b> copayment for each Advanced level hearing aid up to 1 per ear per year.<br><b>\$599</b> copayment for each Premium level hearing aid up to 1 per ear per year.<br>Note: Includes 80 batteries per aid and 3 year warranty.<br>Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase. |
| <b>Inpatient hospital care</b> <ul style="list-style-type: none"> <li>For a Medicare-covered stay at a hospital, you pay:</li> </ul>      | <b>\$250</b> copayment per day for days 1 - 5<br><b>\$0</b> copayment per day for days 6 - 90                                                                                                                       | <b>\$275</b> copayment per day for days 1 - 6<br><b>\$0</b> copayment per day for days 7 - 90                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Inpatient mental health care</b> <ul style="list-style-type: none"> <li>For a Medicare-covered stay at a hospital, you pay:</li> </ul> | <b>\$250</b> copayment per day for days 1 - 5<br><b>\$0</b> copayment per day for days 6 - 90                                                                                                                       | <b>\$275</b> copayment per day for days 1 - 6<br><b>\$0</b> copayment per day for days 7 - 90                                                                                                                                                                                                                                                                                                                                                                                                                    |

| Cost                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2023 (this year)                                                                                                                                                                                                                    | 2024 (next year)                                                                                                                                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | In-Network                                                                                                                                                                                                                          | In-Network                                                                                                                                                                                                                         |
| <ul style="list-style-type: none"> <li>For a Medicare-covered stay at an inpatient psychiatric facility, you pay:</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>\$250</b> copayment per day for days 1 - 5<br><b>\$0</b> copayment per day for days 6 - 90                                                                                                                                       | <b>\$275</b> copayment per day for days 1 - 6<br><b>\$0</b> copayment per day for days 7 - 90                                                                                                                                      |
| <b>Outpatient diagnostic tests, therapeutic services and supplies</b> <ul style="list-style-type: none"> <li>For diagnostic procedures and tests, you pay:               <ul style="list-style-type: none"> <li>at an urgent care center</li> </ul> </li> <li>For advanced imaging services (MRI, MRA, PET, or CT Scan), you pay:               <ul style="list-style-type: none"> <li>at a specialist's office</li> <li>at a freestanding radiology facility</li> <li>at a hospital facility as an outpatient</li> </ul> </li> <li>For basic radiological services, you pay:               <ul style="list-style-type: none"> <li>at a hospital facility as an outpatient</li> <li>at a freestanding radiology facility</li> <li>at an urgent care center</li> </ul> </li> <li>For lab services, you pay:               <ul style="list-style-type: none"> <li>at an urgent care center</li> </ul> </li> </ul> | <b>\$25</b> copayment<br><br><b>\$40</b> copayment<br><b>\$180</b> copayment<br><b>\$250</b> copayment<br><br><b>\$90</b> copayment<br><b>\$35</b> copayment<br><b>\$25</b> copayment<br><br><b>\$25</b> copayment                  | <b>\$65</b> copayment<br><br><b>\$200</b> copayment<br><b>\$200</b> copayment<br><b>\$300</b> copayment<br><br><b>\$125</b> copayment<br><b>\$50</b> copayment<br><b>\$65</b> copayment<br><br><b>\$0</b> copayment                |
| <b>Outpatient hospital observation</b> <ul style="list-style-type: none"> <li>For each Medicare-covered observation services visit, you pay:               <ul style="list-style-type: none"> <li>at a hospital facility as an outpatient</li> </ul> </li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>\$0</b> copayment                                                                                                                                                                                                                | <b>\$275</b> copayment                                                                                                                                                                                                             |
| <b>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</b> <ul style="list-style-type: none"> <li>For each Medicare-covered surgical services visit, you pay:               <ul style="list-style-type: none"> <li>at an ambulatory surgical facility</li> <li>at a hospital facility as an outpatient</li> </ul> </li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>\$200</b> copayment<br><b>\$250</b> copayment                                                                                                                                                                                    | <b>\$250</b> copayment<br><b>\$300</b> copayment                                                                                                                                                                                   |
| <b>Over-the-counter (OTC) items</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>\$100</b> quarterly allowance to buy approved over-the-counter health and wellness products available through our OTC Mail Order provider. Unused amount rolls over to the next quarter and expires at the end of the plan year. | <b>\$60</b> quarterly allowance to buy approved over-the-counter health and wellness products available through our OTC Mail Order provider. Unused amount rolls over to the next quarter and expires at the end of the plan year. |
| <b>Pulmonary rehabilitation services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                    |

| Cost                                                                                                                                                                            | 2023 (this year)                                                                                                                                                                                                                                                                                                                                                                                                  | 2024 (next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                 | In-Network                                                                                                                                                                                                                                                                                                                                                                                                        | In-Network                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <ul style="list-style-type: none"> <li>– at a specialist's office</li> <li>– at a hospital facility as an outpatient</li> </ul>                                                 | <b>\$20</b> copayment<br><b>\$20</b> copayment                                                                                                                                                                                                                                                                                                                                                                    | <b>\$0</b> copayment<br><b>\$0</b> copayment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Skilled nursing facility (SNF) care</b> <ul style="list-style-type: none"> <li>• For a Medicare-covered stay at a skilled nursing facility, you pay:</li> </ul>              | <b>\$0</b> copayment per day for days 1 - 20<br><b>\$196</b> copayment per day for days 21 - 100                                                                                                                                                                                                                                                                                                                  | <b>\$20</b> copayment per day for days 1 - 20<br><b>\$203</b> copayment per day for days 21 - 100                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Supervised Exercise Therapy (SET)</b> <ul style="list-style-type: none"> <li>– at a specialist's office</li> <li>– at a hospital facility as an outpatient</li> </ul>        | <b>\$20</b> copayment<br><b>\$20</b> copayment                                                                                                                                                                                                                                                                                                                                                                    | <b>\$0</b> copayment<br><b>\$0</b> copayment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Transportation</b>                                                                                                                                                           | Covered                                                                                                                                                                                                                                                                                                                                                                                                           | Not Covered                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Urgently needed services</b> <ul style="list-style-type: none"> <li>• For Medicare-covered urgently needed services, you pay:</li> <li>– at an urgent care center</li> </ul> | <b>\$25</b> copayment                                                                                                                                                                                                                                                                                                                                                                                             | <b>\$65</b> copayment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Vision care</b> <ul style="list-style-type: none"> <li>• Routine vision services:</li> </ul>                                                                                 | <b>VIS733</b><br><b>\$0</b> copayment for routine exam up to 1 per year.<br><b>\$300</b> maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.<br>Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year.<br>Maximum benefit coverage amount is limited to one time use per year. | <b>VIS735</b><br><b>\$0</b> copayment for routine exam up to 1 per year.<br><b>\$200</b> maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.<br><b>\$250</b> maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.<br>Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year.<br>Maximum benefit coverage amount is limited to one time use per year. |
| <b>Worldwide coverage</b> <ul style="list-style-type: none"> <li>• For each emergency room visit, you pay:</li> </ul>                                                           | <b>\$90</b> copayment waived if admitted within 24 hours                                                                                                                                                                                                                                                                                                                                                          | <b>\$135</b> 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 |
| <b>MyOption DEN478</b> <ul style="list-style-type: none"><li>• <b>\$39.90 extra</b> monthly premium</li><li>• No deductible</li><li>• <b>\$2,000</b> maximum allowed benefit</li></ul>                                                                                                                                                                            |                | <b>MyOption DEN478</b> <ul style="list-style-type: none"><li>• <b>\$43.70 extra</b> monthly premium</li><li>• No deductible</li><li>• <b>\$2,000</b> maximum allowed benefit</li></ul>                                                                                                                                                                            |                |
| Plan covers up to <b>\$2,000</b> 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.                                                                                                            |                | Plan covers up to <b>\$2,000</b> 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: <ul style="list-style-type: none"><li>• Preventive dental services, such as exams, routine cleanings, etc.</li><li>• Basic dental services, such as fillings, extractions, etc.</li><li>• Major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges, etc.</li></ul> |                | Your benefit can be used for most dental treatments such as: <ul style="list-style-type: none"><li>• Preventive dental services, such as exams, routine cleanings, etc.</li><li>• Basic dental services, such as fillings, extractions, etc.</li><li>• Major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges, etc.</li></ul> |                |
| Note: The allowance cannot be used on cosmetic services and implants.                                                                                                                                                                                                                                                                                             |                | 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.                                                                                                                                                                                                                                                  |                |
|                                                                                                                                                                                                                                                                                                                                                                   |                | • <b>No benefit changes</b>                                                                                                                                                                                                                                                                                                                                       |                |

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](https://www.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 | The deductible is <b>\$200</b> .<br><br>During this stage, you pay <b>\$0</b> cost-sharing for drugs on Tier 1, <b>\$0</b> cost-sharing for drugs on Tier 2, <b>\$47</b> cost-sharing for drugs on Tier 3 and the full cost of drugs on Tier 4 and Tier 5 until you have reached the yearly deductible. | Because we have no deductible, this payment stage does not apply to you. |



## Changes to Your Cost Sharing in the Initial Coverage Stage

| Stage                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2023 (this year)                                                                                                                               | 2024 (next year)                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Stage 2: Initial Coverage Stage</b><br>During this stage, the plan pays its share of the cost of your drugs and <b>you pay your share of the cost.</b><br><br>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 <i>Evidence of Coverage</i> .<br><br>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".<br><br>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:                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Preferred Generic:</b><br>You pay <b>\$0</b> per prescription.                                                                              | <b>Preferred Generic:</b><br>You pay <b>\$0</b> per prescription.                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Generic:</b><br>You pay <b>\$0</b> per prescription.                                                                                        | <b>Generic:</b><br>You pay <b>\$5</b> per prescription.                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Preferred Brand:</b><br>You pay <b>\$47</b> per prescription.<br>You pay <b>\$35</b> per month supply of each covered insulin on this tier. | <b>Preferred Brand:</b><br>You pay <b>\$47</b> per prescription.<br>You pay <b>\$35</b> per month supply of each covered insulin on this tier. |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Non-Preferred Drug:</b><br>You pay <b>\$100</b> per prescription.                                                                           | <b>Non-Preferred Drug:</b><br>You pay <b>\$100</b> per prescription.                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Specialty Tier:</b><br>You pay <b>29%</b> per prescription.<br>You pay <b>\$35</b> per month supply of each covered insulin on this tier.   | <b>Specialty Tier:</b><br>You pay <b>33%</b> per prescription.<br>You pay <b>\$35</b> per month supply of each covered insulin on this tier.   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Once your total drug costs have reached <b>\$4,660</b> , you will move to the next stage (the Coverage Gap Stage).                             | Once your total drug costs have reached <b>\$5,030</b> , you will move to the next stage (the Coverage Gap Stage).                             |

## Changes to your VBID Part D Benefit

You will receive reduced cost sharing on select maintenance inhalers. To qualify, members must have a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and participate in the COPD Inhaler Support Program.

## 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 Humana Gold Plus H6622-001 (HMO)

**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 Humana Gold Plus H6622-001 (HMO).

### 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](https://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 Humana Gold Plus H6622-001 (HMO).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Humana Gold Plus H6622-001 (HMO).
- 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" in the back 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 Humana Gold Plus H6622-001 (HMO)

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 Humana Gold Plus H6622-001 (HMO). 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](http://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](http://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

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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****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.

| <b>WISCONSIN</b>                            |                                                                                                                                                                                                                                                                                                                                          |
|---------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>SHIP Name and Contact Information</b>    | WI State Health Ins. Assist. Program (SHIP)<br>1 West Wilson Street<br>Madison, WI 53703<br>1-800-242-1060 (toll free)<br>711 or 1-800-947-3529 (TTY)<br>1-608-266-1865 (local)<br><a href="http://www.dhs.wisconsin.gov/benefit-specialists/ship.htm">www.dhs.wisconsin.gov/benefit-specialists/ship.htm</a>                            |
| <b>Quality Improvement Organization</b>     | Livanta BFCC-QIO Program<br>10820 Guilford Road<br>Suite 202<br>Annapolis Junction, MD 20701<br>1-888-524-9900<br>1-888-985-8775 (TTY)<br>1-855-236-2423 (Fax)<br><a href="https://livantaqio.com/">https://livantaqio.com/</a>                                                                                                          |
| <b>State Medicaid Office</b>                | Wisconsin Department of Health Services (Medicaid)<br>1 West Wilson Street<br>Madison, WI 53703-3445<br>1-800-362-3002 (toll free)<br>1-608-266-1865 (local)<br>1-800-947-3529 (TTY)<br><a href="http://www.dhs.wisconsin.gov">http://www.dhs.wisconsin.gov</a>                                                                          |
| <b>State Pharmacy Assistance Program(s)</b> | Wisconsin SeniorCare<br>PO Box 6710<br>Madison, WI 53716-0710<br>1-800-657-2038 (toll free)<br><a href="http://www.dhs.wisconsin.gov/seniorcare/">http://www.dhs.wisconsin.gov/seniorcare/</a>                                                                                                                                           |
| <b>AIDS Drug Assistance Program</b>         | Wisconsin AIDS/HIV Drug Assistance and Insurance Assistance Programs<br>Division of Public Health, Attn: ADAP<br>P.O. Box 2659<br>Madison, WI 53701<br>1-800-991-5532<br>1-608-266-1288 (fax)<br>1-608-267-6875<br>1-608-261-6952<br><a href="https://www.dhs.wisconsin.gov/hiv/adap.htm">https://www.dhs.wisconsin.gov/hiv/adap.htm</a> |

# 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](mailto: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

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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 quý vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý 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 대해 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.

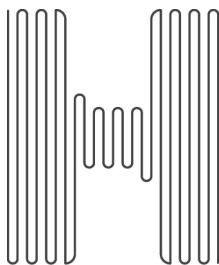
**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-320-1235 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**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。

## This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There is no handwriting or other markings on the paper.

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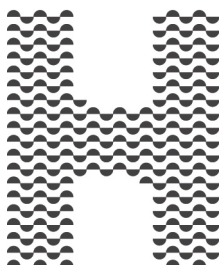
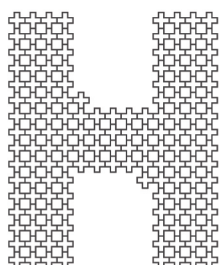
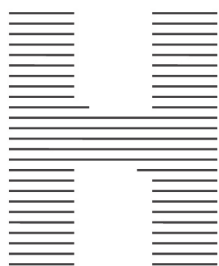
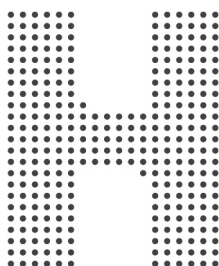
Starting October 15, 2023, you can view and search these 2024 plan documents at **[Humana.com/PlanDocuments](https://www.humana.com/PlanDocuments)**. Here you can see the most up-to-date information about your plan. It's easy to search, so you can find the information you are looking for quickly.

- 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



H6622034000001000ANOC24

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



## Look inside

Here's a summary of your **Humana Gold  
Plus H6622-001 (HMO)** that takes effect on  
January 1, 2024.

**Humana**<sup>®</sup>

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