# PPO

Humana Full Access Giveback (PPO)
H7617-058-000
Select Counties in Michigan
H7617058000MAPDEN27PODPPOF

MI: Alcona, Alger, Allegan, Antrim, Arenac, Baraga, Barry, Bay, Benzie, Berrien, Branch, Cass, Charlevoix, Cheboygan, Clare, Clinton, Crawford, Delta, Dickinson, Eaton, Emmet, Genesee, Gladwin, Grand Traverse, Gratiot, Hillsdale, Houghton, Huron, Ingham, Ionia, Iosco, Iron, Isabella, Jackson, Kalkaska, Kent, Keweenaw, Lake, Lapeer, Leelanau, Lenawee, Livingston, Luce, Macomb, Manistee, Marquette, Mecosta, Menominee, Midland, Missaukee, Monroe, Montcalm, Montmorency, Newaygo, Oakland, Ogemaw, Ontonagon, Osceola, Oscoda, Otsego, Presque Isle, Roscommon, Saginaw, Sanilac, Schoolcraft, Shiawassee, St. Clair, St. Joseph, Tuscola, Van Buren, Washtenaw, Wayne, Wexford

# Enrollment book

## 2027 MAPD

Medicare Advantage prescription drug plan

Humana®

## Quality coverage that's easy to understand

When it comes to healthcare coverage, what you want is clear. Clear costs, clear benefits, and a clear winner when you choose a plan. At Humana, we strive to make our plans easier to understand and compare. So you can feel confident with your Medicare Advantage plan choice. And the comfort of knowing that Humana offers coverage from multiple networks of caring providers.

**Your Medicare Advantage prescription drug (MAPD) plan may have benefits and services beyond the ones below. So check your Summary of Benefits.**

- **All-in-one plans** with prescription drug coverage
- **An annual cap on your out-of-pocket costs** for covered medical services
- May include **dental,* vision or hearing** coverage
- Multiple large plan networks of **doctors, hospitals and pharmacies**
- Easy access to coverage details, claim status and more through a **MyHumana account**



### Health plan expertise, at your service

We specialize in serving those who are Medicare-eligible with benefits, competitive premiums and support on your journey to your best health. We get to know you personally, so we can guide you and help you navigate your care. And you don't have to do it alone.

Not all benefits and resources listed are available on all plans or in all areas. Consult your Evidence of Coverage or ask your licensed sales agent to find out what benefits are included in this plan.

* Limitations and restrictions may apply.

# What's inside

- How this plan works
- Understand your Medicare options
- What's next after you enroll
- Summary of Benefits
- Enrollment documents
- Resources guide

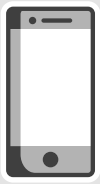
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## Your agent information

Agent name _____

Agent phone number _____

Agent email _____



### Let's talk

Contact the licensed sales agent above. They're ready to walk you through your options and help you enroll.

Humana.

PPO

# How this plan works

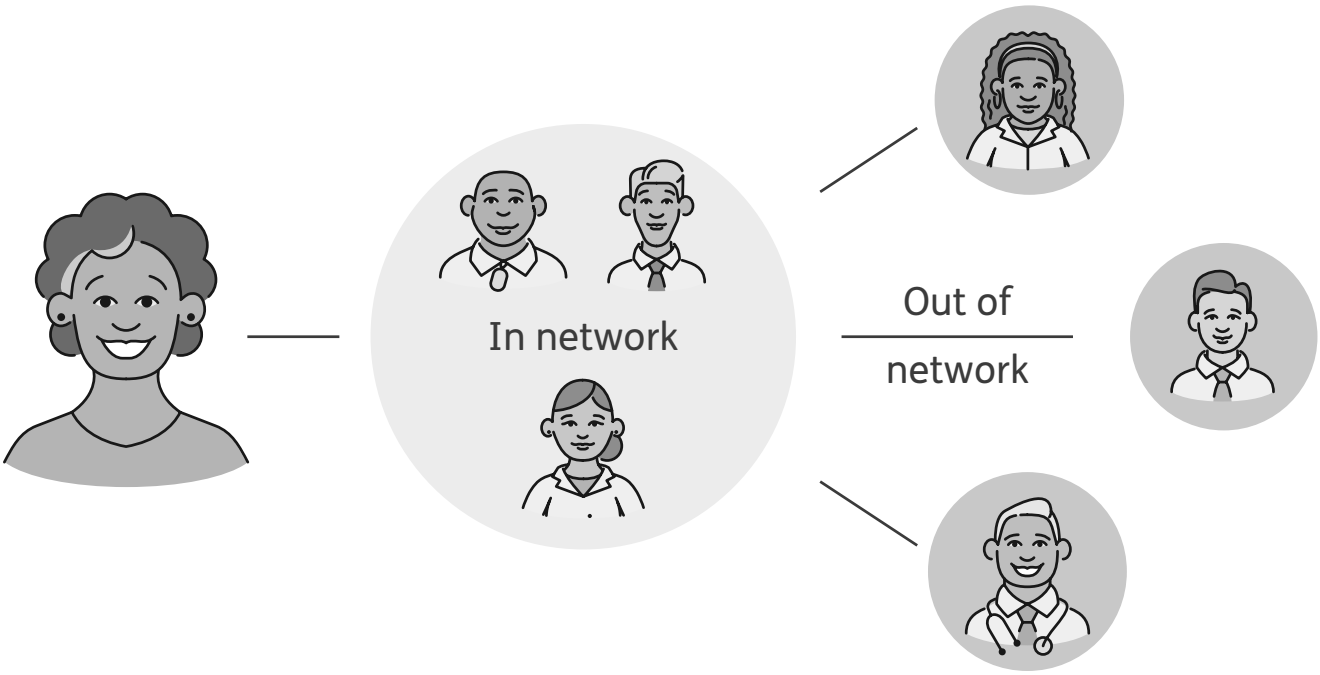
Here's how a PPO Medicare Advantage plan works. (See all your Medicare options on the next page.)

## Preferred provider organization

Preferred provider organization (PPO) plans give you the freedom to get care in or out of network.

## Using a Humana PPO plan

- In-network doctors** and hospitals cost less. They partner with your plan so you may pay less for copays, coinsurance and more.††
- There may be higher cost sharing or no coverage for care from out-of-network providers, except for emergency care. In some cases, the costs are the same in and out of network.‡‡
- No referrals needed to see a specialist.
- The plan may include worldwide coverage for emergency and urgent care when you travel.




** This information is provided for educational purposes only. It is not to be used for medical advice, diagnosis or treatment. Consult your healthcare provider if you have questions or concerns.

†† Any doctor who accepts Medicare and is willing to bill Humana. Humana PPOs may not be available in all areas. Benefits and cost share may vary.

‡‡ Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

# Understand your Medicare options

**Step 1** **Enroll in Original Medicare—offered by the federal government.**



**Part A** helps pay for hospital stays and inpatient care.



**Part B** helps pay for doctor visits and outpatient care.

**Step 2** **After enrolling in Original Medicare, you can explore additional types of coverage—offered by private companies.**

**Option 1:** Choose a Medicare Advantage plan or Medicare Advantage Prescription Drug plan.

**OR**

**Option 2:** Enroll in one or more of these additional plan options.



**Medicare Part C (Medicare Advantage)** is made up of Parts A and B and may include Part D (prescription drug coverage) as well as additional benefits.***

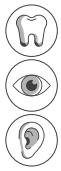
Medicare Advantage enrollees who want **coverage beyond what's included in their Part C plan** have the option of purchasing individual dental or vision (IDV) plans or combined dental, vision and hearing plans.†††



**Medicare Part D** is offered as a stand-alone prescription drug plan (PDP).***



**Medicare Supplement insurance plans** help pay for some of the cost not paid by Original Medicare for covered medical services.

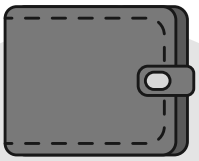


**Individual dental or vision plans or combined dental, vision and hearing plans** can help ensure coverage for all your healthcare needs.†††

*** If you don't enroll in Part D coverage when you're first eligible, you will generally pay a late enrollment penalty fee.

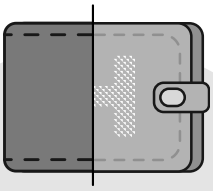
††† Plans are not available in all states. Plan benefits may vary by state. Refer to the plan documents for complete details of coverage. Dental and vision plans, excluding Dental Savings Plus, may have a minimum one-year initial contract period. Payment may include an administration fee. Association membership and fees may be required on some plans in some states. A one-time, non-refundable enrollment fee may apply (the fee is non-refundable as allowed by state requirements). Applicable fees are disclosed at time of enrollment. These are not Medicare plans. For Arizona: This is a solicitation of insurance. A licensed insurance agent/producer may contact you. For Texas: The age or gender on which that rate is based or in the case of IDV, neither age nor gender are used as a basis for the rates; that the rates are illustrative only; that a person should not send money to the issuer in response to the advertisement; and that a person cannot obtain coverage under the health benefit plan without completing application for coverage.

# The Part D prescription drug stages



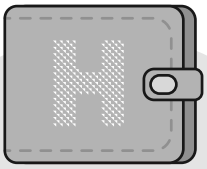
**STAGE 1** Deductible:
**you pay 100%**

- A **deductible** is the amount you pay for your covered prescription drugs before the plan pays its share. **You pay all costs until the deductible is met.**
- Deductible amounts and tier exclusions vary across plans—many plans exclude commonly used medications from the Deductible Stage.



**STAGE 2** Initial Coverage:
**shared cost with insurance company**

- **You pay only your share of the cost** (your copay or coinsurance amount) for covered prescription drugs while the plan pays the remaining cost.
- Both you and your insurance plan pay medication costs until your Part D out-of-pocket costs reach $2,400,‡‡ including what you pay for your deductible.



**STAGE 3** Catastrophic Coverage:
**insurance plan pays 100%**

- **You pay nothing** for the rest of the calendar year.
- The plan pays for the full cost for your covered prescription drugs.



**The amount you pay for your prescriptions******

During **Stage 2: Initial Coverage**, you pay your share of the costs through a copay or coinsurance.

A **copay** is a fixed amount you pay for your prescription medicine, such as $10 or $20, each time you fill a prescription.

**Coinsurance** is when you pay a percentage of the cost of the medicine, such as 20%. For example, if your medicine costs $100 and you have 20% coinsurance, you would pay $20.

‡‡ Announcement of Calendar Year (CY) 2027 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies on page 95. https://www.cms.gov/files/document/2027-announcement.pdf

**** The amount you pay as a copay or coinsurance depends on your health plan, the Part D stage you are in and the tier of your medication.

# What's next after you enroll

Once your application is approved by the Centers for Medicare & Medicaid Services (CMS), we'll send you:

**A notice confirming it was approved**

**Your Humana member ID card**

### Getting the care you deserve

Preventive check-ins, such as cancer screenings, Annual Wellness Visits and routine lab tests can help catch health issues early. To help you stay on track, Humana, your providers and specialized partners may reach out to help with care or medications, if needed.




Go to **Humana.com/LogOn** to set up your secure MyHumana account and update your communication preferences.

**In your MyHumana account, you can easily access:**

- Plan messages and notifications (such as confirmation of enrollment)
- Summary of Benefits
- Annual Notice of Change
- Claims and Explanation of Benefits (SmartSummary®)
- Your plan ID card
- Find a doctor or other healthcare provider
- Medication information and resources
- Health and wellness information

2027

# Summary of Benefits

## Humana Full Access Giveback (PPO)

Michigan

H7617_SB_MAPD_PPO_058000_2027_M

Our service area includes the following county/counties in Michigan: Alcona, Alger, Allegan, Antrim, Arenac, Baraga, Barry, Bay, Benzie, Berrien, Branch, Cass, Charlevoix, Cheboygan, Clare, Clinton, Crawford, Delta, Dickinson, Eaton, Emmet, Genesee, Gladwin, Grand Traverse, Gratiot, Hillsdale, Houghton, Huron, Ingham, Ionia, Iosco, Iron, Isabella, Jackson, Kalkaska, Kent, Keweenaw, Lake, Lapeer, Leelanau, Lenawee, Livingston, Luce, Macomb, Manistee, Marquette, Mecosta, Menominee, Midland, Missaukee, Monroe, Montcalm, Montmorency, Newaygo, Oakland, Ogemaw, Ontonagon, Osceola, Oscoda, Otsego, Presque Isle, Roscommon, Saginaw, Sanilac, Schoolcraft, Shiawassee, St. Clair, St. Joseph, Tuscola, Van Buren, Washtenaw, Wayne, Wexford.

## Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **888-873-0686 (TTY: 711)**.

### Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **Humana.com/medicare** or call **888-873-0686 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary (Drug Guide) to make sure your drugs are covered.

### Understanding Important Rules

- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copays/coinsurance may change on January 1, 2028.
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ This plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copay/coinsurance for services received by non-contracted providers.

# Let's talk about Humana Full Access Giveback (PPO)

Find out more about the Humana Full Access Giveback (PPO) plan – including the health and drug services it covers – in this easy-to-use booklet.

Humana Full Access Giveback (PPO) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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

## To be eligible

To join Humana Full Access Giveback (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

## Plan name

Humana Full Access Giveback (PPO)

## How to reach us

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

If you're **not** a member of this plan, call toll free: **888-873-0686 (TTY: 711)**.

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

Or visit our website: **Humana.com/Medicare**

## More about Humana Full Access Giveback (PPO)

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

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

As a member it's a good idea to select a doctor as your Primary Care Provider (PCP). Humana Full Access Giveback (PPO) has a network of doctors, hospitals, pharmacies and other providers.

## A healthy partnership

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

# Monthly Premium, Deductible and Limits

| PLAN COSTS | |
|---|---|
| **Monthly plan premium** | **$0**<br>You must keep paying your Medicare Part B premium. |
| **Part B premium reduction**[1] | Your plan will reduce your Monthly Part B premium by up to **$99** but by no more than Original Medicare's Part B Premium for 2027. |
| **Medical deductible** | **$500** combined deductible<br>The following services listed are excluded from the combined in-network and out-of-network deductible:<br><br>In-Network only:<br>Ambulance Services<br>Chemotherapy Drugs and Administration<br>Continuous Glucose Monitor<br>Diabetic Monitoring Supplies<br>Diagnostic Colonoscopy<br>Diagnostic Mammography<br>Durable Medical Equipment<br>Lab Services<br>Other Medicare Part B Drugs<br>Outpatient Blood Services<br>Outpatient Therapies (Occupational, Physical, and Speech)<br>Primary Care Physician's Office<br>Specialist's Office<br><br>Both In-Network and Out-of-Network:<br>Emergency Room Services<br>Medicare Covered Preventive Services<br>Medicare Part B Insulin Drugs<br>Urgently Needed Services at Urgent Care Centers<br>Services not covered by Original Medicare (i.e., Supplemental Benefits) |
| **Pharmacy (Part D) deductible** | **$0** deductible for Tier 1 and Tier 2<br>**$150** deductible for Tier 3, Tier 4 and Tier 5 |
| **Medical Maximum out-of-pocket responsibility** | **$9,850** in-network<br>**$14,800** combined in- and out-of-network<br>The most you pay for copays, coinsurance and other costs for covered medical services for the year. |

[1]It could take up to 120 days for the Social Security Administration to complete their processing. This means you may not see the increase in your Social Security check for up to 120 days after the effective date of this plan. Any missed increases will be added to your next check after processing is complete.

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

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# Medical Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **INPATIENT HOSPITAL COVERAGE** | | |
| This plan covers an unlimited number of days for an inpatient stay. | **$450** copay per day for days 1-5<br>**$0** copay per day for days 6-90 | **$450** copay per day for days 1-5<br>**$0** copay per day for days 6-90 |
| **OUTPATIENT HOSPITAL COVERAGE** | | |
| **Diagnostic colonoscopy** | **$0** copay | **$0** copay |
| **Diagnostic mammography** | **$0** copay | **$0** copay |
| **Surgery services** | **$550** copay | **$550** copay |
| **AMBULATORY SURGERY CENTER** | | |
| **Diagnostic colonoscopy** | **$0** copay | **$0** copay |
| **Surgery services** | **$450** copay | **$450** copay |
| **DOCTOR VISITS** | | |
| **Primary care provider (PCP)** | | |
| • PCP's office | **$0** copay | **$0** copay |
| • Telehealth | **$0** copay | **Not Covered** |
| **Specialist** | | |
| • Specialist's office | **$50** copay | **$50** copay |
| • Telehealth | **$50** copay | **Not Covered** |
| **PREVENTIVE CARE** | | |
| This plan covers all Medicare preventive services including:<br>**Cancer Screenings**<br>• Breast cancer screening (mammogram)<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screening<br>• Lung cancer screening<br>• Prostate cancer screening<br><br>**Cardiovascular (heart) Care**<br>• Abdominal aortic aneurysm screening<br>• Cardiovascular disease risk reduction visit<br>• Cardiovascular disease screenings | **$0** copay | **$0** copay |

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# Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Diabetes Care**<br>• Diabetes screenings<br>• Diabetes self-management training<br>• Medicare Diabetes Prevention Program (MDPP) | | |
| **Dietary Guidance and Support**<br>• Medical nutrition therapy<br>• Obesity screening and therapy | | |
| **Routine Screenings and Immunizations**<br>• Annual Wellness Visit (AWV)<br>• Immunizations<br>• Routine physical exam<br>• "Welcome to Medicare" preventive visit | | |
| **Screenings and Counseling Services**<br>• Bone mass measurement<br>• Depression screening<br>• Glaucoma screening<br>• HIV screening<br>• Screening & counseling to reduce alcohol misuse<br>• Sexually transmitted infections (STIs) screening and counseling<br>• Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)<br>Any additional preventive services approved by Medicare during the contract year will be covered. | | |

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## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **EMERGENCY CARE** | | |
| **Emergency services at emergency room**<br>If you are admitted to the same hospital within 24 hours for the same condition, you pay $0 for the emergency care you received. When placed in observation, member pays observation cost-share instead of emergency room cost-share. | **$115** copay | **$115** copay |
| **URGENTLY NEEDED SERVICES** | | |
| • **Telehealth**<br>• **Urgent care center**<br>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical attention. | **$40** copay<br>**$40** copay | **Not Covered**<br>**$40** copay |
| **WORLDWIDE COVERAGE** | | |
| • **Emergency ambulance**<br>• **Emergency room - Hospital**<br>• **Urgent care center**<br>If you have an emergency or urgently needed service outside of the U.S and its territories, you will be responsible to pay for the rendered services upfront and can request reimbursement.<br>If you are admitted to the same hospital within 24 hours for the same condition, you pay $0 for the emergency care you received. | | **$325** copay per date of service<br>**$115** copay<br>**$40** copay |

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# Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **DIAGNOSTIC SERVICES, LABS AND IMAGING** | | |
| **Advanced imaging services (MRI, MRA, PET and CT scans)** | | |
| • Freestanding radiological facility | **$190** copay | **$190** copay |
| • Outpatient hospital | **$300** copay | **$300** copay |
| • PCP's office | **$280** copay | **$280** copay |
| • Specialist's office | **$280** copay | **$280** copay |
| **Basic radiological services (X-rays)** | | |
| • Freestanding radiological facility | **$35** copay | **$35** copay |
| • Outpatient hospital | **$100** copay | **$100** copay |
| • PCP's office | **$0** copay | **$0** copay |
| • Specialist's office | **$50** copay | **$50** copay |
| • Urgent care center | **$40** copay | **$40** copay |
| **Diagnostic mammography** | | |
| • Freestanding radiological facility | **$0** copay | **$0** copay |
| • Specialist's office | **$0** copay | **$0** copay |
| **Diagnostic procedures and tests** | | |
| • Outpatient hospital | **$100** copay | **$100** copay |
| • PCP's office | **$0** copay | **$0** copay |
| • Specialist's office | **$50** copay | **$50** copay |
| • Urgent care center | **$40** copay | **$40** copay |
| **Lab services** | | |
| • Freestanding laboratory | **$0** copay | **$0** copay |
| • Outpatient hospital | **$0** copay | **$0** copay |
| • PCP's office | **$0** copay | **$0** copay |
| • Specialist's office | **$0** copay | **$0** copay |
| • Urgent care center | **$0** copay | **$0** copay |
| **Nuclear medicine and services** | | |
| • Freestanding radiological facility | **$325** copay | **$325** copay |
| • Outpatient hospital | **$700** copay | **$700** copay |
| **Sleep study** | | |
| • Member's home | **$0** copay | **$0** copay |
| • Outpatient hospital | **$175** copay | **$175** copay |
| • Specialist's office | **$100** copay | **$100** copay |

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

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## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Therapeutic radiology (Radiation therapy)** | | |
| • Freestanding radiological facility | **20%** of the cost | **20%** of the cost |
| • Outpatient hospital | **20%** of the cost | **20%** of the cost |
| • Specialist's office | **$50** copay | **$50** copay |
| **HEARING SERVICES** | | |
| **Medicare-covered hearing** | **$50** copay | **$50** copay |
| **Mandatory supplemental hearing benefit** | **HER128**<br>• **$0** copay for fitting, routine hearing exams up to 1 per year.<br>• **$0** copay for follow-up provider visits up to 3 per year.<br>• **$575** copay for each Level 1 prescription hearing aid up to 1 per ear per year.<br>• **$750** copay for each Level 2 prescription hearing aid up to 1 per ear per year.<br>• Note: Includes 3 years of batteries per non-rechargeable aid (up to 60 cells per ear, per year) and 3 year warranty.<br>• One fitting and three follow-up provider visits during first year following hearing aid purchase, with the original provider. | **HER128**<br>• **95%** of the cost for routine hearing exams up to 1 per year.<br>• **95%** of the cost for fitting up to 1 per year.<br>• **95%** of the cost for follow-up provider visits up to 3 per year.<br>• **95%** of the cost for each prescription hearing aid up to 1 per ear per year.<br>• Member is required to pay the full cost at the time of service when utilizing an out-of-network provider.<br>• To receive reimbursement from Humana for eligible items/services, the member must submit required documentation.<br>• Reimbursement will be limited to up to **5%** of the allowed amount on eligible items/services.<br>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |

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

# Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **DENTAL SERVICES** | | |
| **Medicare-covered dental** | **$50** copay | **$50** copay |
| **Mandatory supplemental dental benefit**<br>Limitations and exclusions may apply. Please see your Evidence of Coverage (EOC) for additional details.<br><br>**Benefit limits**<br>• Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage.<br>• Dental benefits under this plan may not cover all ADA procedure codes. Any services received that are not listed will not be covered by the plan and will be the member's responsibility.<br>• The member is responsible for any amount above the annual maximum benefit coverage amount.<br>• Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. Information regarding each plan is available at **Humana.com/sb**.<br><br>**In-network providers**<br>• In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). | **DEN353**<br>• **$0** copay for amalgam filling, resin-based composite filling - back, resin-based composite filling - front up to 1 per tooth per surface every 2 years.<br>• **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.<br>• **$0** copay for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.<br>• **$0** copay for panoramic film or diagnostic x-rays up to 1 every 5 years.<br>• **$0** copay for necessary nitrous oxide/analgesia with covered service up to 1 unit(s) per visit.<br>• **$0** copay for bitewing x-rays, scaling for moderate inflammation up to 1 per year.<br>• **$0** copay for emergency diagnostic exam, periodic oral exam, prophylaxis (cleaning) up to 2 per year.<br>• **$0** copay for periodontal maintenance up to 4 per year.<br>• **$1,000** combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits. | **DEN353**<br>• **$0** copay for amalgam filling, resin-based composite filling - back, resin-based composite filling - front up to 1 per tooth per surface every 2 years.<br>• **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.<br>• **$0** copay for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.<br>• **$0** copay for panoramic film or diagnostic x-rays up to 1 every 5 years.<br>• **$0** copay for necessary nitrous oxide/analgesia with covered service up to 1 unit(s) per visit.<br>• **$0** copay for bitewing x-rays, scaling for moderate inflammation up to 1 per year.<br>• **$0** copay for emergency diagnostic exam, periodic oral exam, prophylaxis (cleaning) up to 2 per year.<br>• **$0** copay for periodontal maintenance up to 4 per year.<br>• **$1,000** combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.<br>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |

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

## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| • If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule (but any applicable coinsurance payment still applies). Visiting an in-network provider may result in significant savings. The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator for our nationwide network can be found at **Humana.com/FindCare**. | | |
| **Out-of-network providers**<br>• Out-of-network dentists have not agreed to provide services at contracted fees.<br>• The out-of-network provider may bill the member for more than what the plan pays, even for services listed with no member cost share. Members are responsible for this difference between Humana's reimbursement and the out-of-network provider's charges. This is known as balance billing.<br>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions.<br>• Members may be billed by the out-of-network provider for any amount greater than the payment made by Humana to | | |

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

## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| the provider. Please see above for provider locator instructions.<br><br>**Provider reimbursements**<br>• Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement.<br>• The coinsurance level will apply to the average negotiated in-network fee schedule (INFS) usual and customary fees in your area.<br>• See Chapter 2 Payment Requests Contact Information in your Evidence of Coverage or visit **Humana.com** for information on requesting reimbursement. | | |
| **VISION SERVICES** | | |
| **Eyewear (post cataract surgery)** | **$0** copay | **$0** copay |
| **Medicare-covered diabetic eye exam** | **$0** copay | **$0** copay |
| **Medicare-covered vision services**<br>The provider locator for Medicare-covered vision can be found at **Humana.com/FindCare**. | **$50** copay | **$50** copay |
| **Mandatory supplemental vision benefit**<br>Please inform the network provider that you are part of the Humana Medicare Insight Network. NOTE: The network of providers for your supplemental vision benefits through Humana | **VIS694**<br>• **$0** copay for routine exam up to 1 per year.<br>• **$75** combined maximum benefit coverage amount per year for routine exam.<br>• **$50** maximum benefit coverage amount per year for | **VIS694**<br>• **$0** copay for routine exam up to 1 per year.<br>• **$75** combined maximum benefit coverage amount per year for routine exam.<br>• **$50** maximum benefit coverage amount per year for |

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

## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| Medicare Insight Network may be different than the network of providers for the Medicare-covered vision benefits. The provider locator can be found at **Humana.com/FindCare**. Benefit is applied toward the retail price. Member is responsible for any costs above the plan approved amount. Lost or broken materials are not covered. This benefit is limited to a one-time use per year. Any remaining benefit dollars do not "roll over" to a future purchase. Eyeglass lens options may be available with the maximum benefit coverage amount up to one pair per year. Benefits are offered on a calendar basis. Any amount unused by the end of the year will expire. Copayments, coinsurances, and deductibles paid for supplemental benefits do not count toward your maximum out-of-pocket amount. | contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.<br>• OR<br>• **$100** 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.<br>• Maximum benefit coverage amounts cannot be combined.<br>PLUS providers are part of the Humana Medicare Insight Network and will display the PLUS Provider indicator in the provider locator search results found at **Humana.com/FindCare**. | 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.<br>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.<br>• Maximum benefit coverage amounts cannot be combined. |
| **MENTAL HEALTH SERVICES** | | |
| **Inpatient**<br>This plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital | **$450** copay per day for days 1-4<br>**$0** copay per day for days 5-90 | **$450** copay per day for days 1-4<br>**$0** copay per day for days 5-90 |
| **Mental health therapy visits** | | |
| • Outpatient hospital | **$35** copay | **$35** copay |
| • Specialist's office | **$30** copay | **$30** copay |
| • Telehealth | **$30** copay | **Not Covered** |
| **Outpatient substance abuse services** | | |
| • Outpatient hospital | **$35** copay | **$35** copay |
| • Specialist's office | **$30** copay | **$30** copay |
| • Telehealth | **$30** copay | **Not Covered** |

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

## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **SKILLED NURSING FACILITY (SNF)** | | |
| This plan covers up to 100 days in a SNF | **$0** copay per day for days 1-20<br>**$221** copay per day for days 21-100 | **$0** copay per day for days 1-20<br>**$221** copay per day for days 21-100 |
| **AMBULANCE** | | |
| **Air** | **$1800** copay per date of service | **$1800** copay per date of service |
| **Ground** | **$325** copay per date of service | **$325** copay per date of service |
| **TRANSPORTATION** | | |
| | **Not Covered** | **Not Covered** |
| **MEDICARE PART B DRUGS**<br>Some rebatable Part B drugs may be subject to a lower coinsurance. | | |
| **Allergy shots and serum** | | |
| • PCP's office | **$0** copay | **$0** copay |
| • Specialist's office | **$0** copay | **$0** copay |
| **Chemotherapy drugs** | | |
| • Outpatient hospital | **20%** of the cost | **20%** of the cost |
| • Specialist's office | **20%** of the cost | **20%** of the cost |
| **Other Part B drugs** | | |
| • Outpatient hospital | **20%** of the cost | **20%** of the cost |
| • PCP's office | **20%** of the cost | **20%** of the cost |
| • Pharmacy | **20%** of the cost | **20%** of the cost |
| • Specialist's office | **20%** of the cost | **20%** of the cost |
| **Part B Insulin** | | |
| • Outpatient hospital | **20%** of the cost | **20%** of the cost |
| • PCP's office | **20%** of the cost | **20%** of the cost |
| • Pharmacy | **20%** of the cost | **20%** of the cost |
| • Specialist's office | **20%** of the cost | **20%** of the cost |
| You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan. | | |

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

# Prescription Drug Benefits

| PLAN HIGHLIGHTS | |
|---|---|
| **$0 copays** | **$0** copays at select pharmacy locations and tiers. Additional details below. |
| **Deductible** | **$0** deductible for Tier 1 and Tier 2 |
| **Insulin costs** | You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan. |
| **100-day supply** | Up to 100-day supply on eligible drugs |
| **$0 vaccines** | **$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) |

## DEDUCTIBLE

**$0** deductible for Tier 1 and Tier 2. This plan has a **$150** deductible for Tier 3, Tier 4 and Tier 5 drugs. You pay the full cost of these drugs until you reach **$150**. Then, you only pay your cost-share, entering into the Initial Coverage Stage.

## INITIAL COVERAGE

You pay the following until your total yearly out-of-pocket drug costs reach **$2,400**. Once you reach this amount, you will enter the Catastrophic Stage.

| Pharmacy Cost-Sharing | | | | | | |
|---|---|---|---|---|---|---|
| | **Retail Cost-Sharing** Includes all in-network retail pharmacies | | **Standard Mail-Order Cost-Sharing** | | **Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy® | |
| **Day supply** | **30-day** | **100-day*** | **30-day** | **100-day*** | **30-day** | **100-day*** |
| **Tier 1:** Preferred Generic | $0 | $0 | $0 | $0 | $0 | $0 |
| **Tier 2:** Generic | $0 | $0 | $0 | $0 | $0 | $0 |
| **Tier 3:** Preferred Brand | 17% | 17% | 17% | 17% | 17% | 14% |
| **Tier 4:** Non-Preferred Drug | 50% | 50% | 50% | 50% | 50% | 50% |
| **Tier 5:** Specialty Tier | 31% | N/A | 31% | N/A | 31% | N/A |

You can fill your prescriptions in several ways, including through retail and mail-order pharmacies. For Humana plans, CenterWell Pharmacy® is the preferred mail-order pharmacy with cost-sharing benefits. To learn more, visit **CenterWellPharmacy.com**.

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

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

| Insulin Cost-Sharing | | | | | | |
|---|---|---|---|---|---|---|
| | **Retail Cost-Sharing** Includes all in-network retail pharmacies | | **Standard Mail-Order Cost-Sharing** | | **Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy® | |
| **Day supply** | **30-day** | **100-day*** | **30-day** | **100-day*** | **30-day** | **100-day*** |
| **Tier 1:** Preferred Generic | $0 | $0 | $0 | $0 | $0 | $0 |
| **Tier 2:** Generic | $0 | $0 | $0 | $0 | $0 | $0 |
| **Tier 3:** Preferred Brand | 17% up to $35 | 17% up to $105 | 17% up to $35 | 17% up to $105 | 17% up to $35 | 14% up to $105 |
| **Tier 4:** Non-Preferred Drug | 25% up to $35 | 25% up to $105 | 25% up to $35 | 25% up to $105 | 25% up to $35 | 25% up to $105 |
| **Tier 5:** Specialty Tier | 25% up to $35 | N/A | 25% up to $35 | N/A | 25% up to $35 | N/A |

*Not all tiers may include insulin. Please refer to your Prescription Drug Guide to confirm insulin coverage. You won't pay more than **$35** for a one-month (up to 30-day) supply of each plan-covered insulin product regardless of cost-sharing tier, even if you haven't paid your deductible.

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

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

**CATASTROPHIC COVERAGE**

After your total out-of-pocket costs reach **$2,400** you pay **$0** for plan-covered Part D drugs.

**EXTRA HELP**

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

Prior to reaching your annual **$2,400** out-of-pocket limit, you will pay one of the following depending on your level of Extra Help:

- **$5.80** for generic/preferred multi-source drug or biosimilar; **$14.40** for any other drug; OR
- **$1.65** for generic/preferred multi-source drug or biosimilar; **$5.00** for any other drug; OR
- **$0** for all drugs

After reaching your annual **$2,400** out-of-pocket limit, you will pay **$0** for the remainder of the calendar year, regardless of the level of Extra Help you receive. Additional information will be available on your LIS rider.

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

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

## Additional Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Acupuncture services (Medicare-covered)** | **$50** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year. | **$50** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.<br>Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |
| **Chiropractic services (Medicare-covered)** | **$15** copay | **$15** copay |
| **Podiatry services (Medicare-covered)** | **$50** copay | **$50** copay |
| **MEDICAL EQUIPMENT/SUPPLIES** | | |
| **Continuous glucose monitor (CGM)** | | |
| • DME provider | **20%** of the cost | **20%** of the cost |
| • Pharmacy | **20%** of the cost | **20%** of the cost |
| • Preferred pharmacy | **$0** copay | **Not Covered** |
| **Diabetic monitoring supplies** | | |
| • Diabetic supplier | **20%** of the cost | **20%** of the cost |
| • Network retail pharmacy | **10%** of the cost | **10%** of the cost |
| • Preferred diabetic supplier | **$0** copay | **Not Covered** |
| **Durable medical equipment (DME)** | **10%** of the cost | **10%** of the cost |
| **Medical supplies at medical supplier** | **10%** of the cost | **10%** of the cost |
| **Prosthetics devices and related supplies at prosthetics provider** | **10%** of the cost | **10%** of the cost |
| **REHABILITATION SERVICES** | | |
| **Cardiac rehabilitation services** | | |
| • Outpatient hospital | **$15** copay | **$15** copay |
| • Specialist's office | **$15** copay | **$15** copay |
| **Occupational therapy** | | |
| • Comprehensive outpatient rehab facility | **$24** copay | **$24** copay |
| • Outpatient hospital | **$24** copay | **$24** copay |
| • Specialist's office | **$24** copay | **$24** copay |

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

## Additional Benefits (cont.)

| | | |
|---|---|---|
| **Physical therapy** | | |
| • Comprehensive outpatient rehab facility | **$24** copay | **$24** copay |
| • Outpatient hospital | **$24** copay | **$24** copay |
| • Specialist's office | **$24** copay | **$24** copay |
| **Pulmonary rehabilitation** | | |
| • Outpatient hospital | **$15** copay | **$15** copay |
| • Specialist's office | **$15** copay | **$15** copay |
| **Speech therapy** | | |
| • Comprehensive outpatient rehab facility | **$24** copay | **$24** copay |
| • Outpatient hospital | **$24** copay | **$24** copay |
| • Specialist's office | **$24** copay | **$24** copay |
| **Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD)** | | |
| • Outpatient hospital | **$15** copay | **$15** copay |
| • Specialist's office | **$15** copay | **$15** copay |

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

# More benefits with this plan

Enjoy some of these extra benefits included in this plan.
This is a summary of what we cover. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of coverage and services. Visit **Humana.com/PlanInformation** to view a copy of the EOC or call **888-873-0686**.

### Travel Coverage

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

### Humana Well Dine® Meal Program

**$0** copayment for Humana Well Dine® meal program.

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

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

Limited to 4 times per year.

Out-of-network: You are required to pay the full cost at the time of service when utilizing an out-of-network provider. Humana will reimburse you 5% of the allowed amount on eligible items/services.

To receive reimbursement from Humana for eligible items/services, the member must submit required documentation.

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

### Rewards and Incentives - Go365® by Humana

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

### SilverSneakers® fitness program

**$0** copayment for SilverSneakers®.

The fitness program includes access to participating locations and signature group exercise classes led by certified instructors.

This benefit also connects you to a support network and virtual resources through live classes, on-demand videos and through a mobile app.

Go to SilverSneakers.com to learn more about your benefit.

Out-of-network: **95%** coinsurance for out-of-network fitness centers.

Member is required to pay the full cost at the time of service when utilizing an out-of-network fitness center.

To receive reimbursement from Humana for eligible items/services, the member must submit required documentation.

Reimbursement will be limited to up to **5%** of the allowed amount on eligible items/services.

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

# Optional Supplemental Benefits

Customize your coverage for an extra monthly premium. You can enroll in the following to help create your Medicare plan.

**$35.50**
Monthly premium

**MyOption DEN972**
MyOption DEN972 is an Optional Supplemental Benefit (OSB) package that can be purchased for an additional monthly premium to replace any Mandatory Supplemental Dental Benefits that are offered within your Medicare Advantage plan. If purchased, the OSB will entirely replace the Mandatory Supplemental dental coverage defined in your benefits package. This means you should disregard any language in the Mandatory Supplemental Dental Benefit section contained in Chapter 4 of the Evidence of Coverage (EOC). When you enroll, you will receive a new ID card showing your new DEN972 listed on the back. Any claim paid under the current year Mandatory Supplemental Benefit will apply toward the annual OSB maximum plan benefit.

My Options, My Choice Adding Benefits to Your Plan:
You're unique and have unique needs. That's why Humana offers Optional Supplemental Benefits (OSB). For an extra monthly premium, you can customize your Humana Medicare Advantage plan. The information in this booklet will tell you about the benefits you can add to your plan. You can add these extra benefits when you sign up for your Medicare Advantage plan. You can also add these benefits within the first 3 months of enrollment in your Medicare Advantage plan by contacting your agent or calling OSB sales at 888-413-7026. You can call us seven days a week from 8 a.m. to 8 p.m. Please note that our automated phone system may answer your call during weekends and holidays.

MyOption (DEN972) The MyOption Dental benefit helps make it easy for you to plan for your dental care. This benefit has no deductible. For detailed information on this OSB, please see the EOC.

# Find out **more**

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

You can see this plan's **Drug Guide** at our website at **Humana.com/druglist** or call us at the number listed at the beginning of this booklet and we will send you one.

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

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

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

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

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

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

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

## More information is just a click away.

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

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

## Activate your secure MyHumana account.

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

### Already have an account?

Go to **Humana.com/Member/ManageYourAccount** and log in.

### Don't have an account yet?

Create one using the same link above in just minutes.

## Receiving information about other insurance products

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

# Notice of Non-Discrimination

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

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).

- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

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

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

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

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

GHHNDN2026HUM_0526

# Notice of Availability - Auxiliary Aids and Services Notice



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

አማርኛ [Amharic]፦ነፃ ቋንቋ፣ አጋዥ ማዳመጫ፣ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችም ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسّيق البديل مجاناً. اتصل على الرقم **877-320-1235 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք **877-320-1235 (TTY՝ 711)** հեռախոսահամարով:

Bǎsɔ́ɔ̀ [Bassa]: Wudu-xwíníín-mú-zà-zà kǔà, hwòdǒ-fɔ́nɔ́-nyɔ̀,, kè nyɔ-ɓɔ̌-po-kà ɓě ɓé wa nyuɛsé wídí pɛ́è-pɛ́èdɔ̀ kɔ.̌ Ɓá **877-320-1235 (TTY: 711)**.

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

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

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

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

Hrvatski [Croatian]: Dostupne su besplatne jezične usluge, usluge dodatne pomoći i alternativnog formata. Nazovite **877-320-1235 (TTY: 711)**.

فارسی [Farsi] : خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **877-320-1235 (TTY: 711)** تماس بگیرید.

Français [French]: Des services gratuits d'assistance linguistique, d'aide auxiliaire et de format alternatif sont disponibles. Appelez le **877-320-1235 (ATS : 711)**.

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

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

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

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

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

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

Bekee [Igbo]: Asụsụ n'efu, enyemaka nkwarụ, na ọrụ usoro ndị ọzọ dị. Kpọọ **877-320-1235 (TTY: 711)**.

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

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

ភាសាខ្មែរ [Khmer]៖ សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបានฯ ទូរសព្ទទៅលេខ **877-320-1235 (TTY: 711)** ฯ

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

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

Diné [Navajo]: Saad bee áná'álwo', bee haz'áanii, dóó naaltsoos t'áá ajiłii'ígíí bee ak'e'elyaaígíí t'áá jiik'eh hóló. **877-320-1235 (TTY: 711)** bich'į' hodíilnih.

नेपाली [Nepali]: नि:शुल्क भाषा सेवा, सहायक सामग्री र वैकल्पिक ढाँचाका सेवाहरू उपलब्ध छन् । **877-320-1235 (TTY: 711)** मा कल गर्नुहोस् ।

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

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

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

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

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

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

தமிழ் [Tamil]: மொழி,, உதவிப் பொருட்கள் மற்றும் மாற்று வடிவமைப்புச் சேவைகள் இலவசமாகக் கிடைக்கின்றன. **877-320-1235 (TTY: 711)** எண்ணை அழைக்கவும்.

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

اردو [Urdu]: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال **877-320-1235 (TTY: 711)**۔

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

Òyìnbó [Yoruba]: Àwọn iṣẹ́ àtìlẹ́hìn ìrànlọ́wọ́ èdè, àti ọ̀nà kíkà míràn wà lárọ̀wọ́tó lọ́fẹ̀ẹ́.
Pe **877-320-1235 (TTY: 711)**.

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

# Notes

# Notes

# Notes

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

Important information about this plan

Humana.com

H7617_SB_MAPD_PPO_058000_2027_M

Humana®

# Learn about this plan's drug coverage with the Prescription Drug Guide

The guide is a list of prescription drugs this plan covers. It is also called a formulary or drug list. The guide:

- **Lists all the generic and brand-name drugs covered**
- **Is available in many languages**
- **Is regularly updated by doctors and pharmacists**
- **Can be viewed on your smartphone, tablet, computer, or printed**

View this plan's guide at **huma.na/20270010PDG**.
You can also scan the QR code with your smartphone or tablet's camera.

**Have questions or need a printed copy?** Call Customer Care at **800-457-4708 (TTY: 711).**
Oct. 1 – March 31: Daily, 8 a.m. – 8 p.m.
Apr. 1 – Sept. 30: Monday – Friday, 8 a.m. – 8 p.m.

CenterWell™ Pharmacy

Find retail and mail-order pharmacies at **Humana.com/Pharmacy**. CenterWell Pharmacy® mail delivery is one of many options in your pharmacy network. Check this plan's Evidence of Coverage for more about filling prescriptions.

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# Care and communication on your terms

Your privacy and well-being are important to us. There may be times when you want a family member or friend to talk to Humana on your behalf.

To make that possible, you must first complete a consent for release of protected health information (PHI) form. This form will allow you to choose a trusted individual who can have access to your protected health information. We would consider this person to be your family, friend or caregiver.

This is not a power of attorney (POA). To have someone help you enroll or to request account changes or updates, you must submit a POA or other authorization under state law to allow them to act on your behalf. You can submit POA and PHI consent forms together.



**If you complete the PHI form and grant authorization to someone, we will consider that individual your caregiver who can:**

- Speak to Humana on your behalf about the plan—but may not make or request any account changes or updates (unless they are your POA or have other legal authorization from the state to act on your behalf)
- Keep track of your benefits and claims
- Get answers to healthcare coverage questions
- Receive helpful information and advice on caregiving from Humana



**How to get started***

You have three options for completing and submitting your consent form.

1. If you have a MyHumana account or plan to create one after enrolling, sign in to your account at **account.Humana.com**. Once signed in, use the search bar at the top right of the page and type in “give shared access” and follow the instructions.
2. Your agent can utilize one of our sales systems to help you complete a consent form electronically as part of your enrollment.
3. Complete the paper form included with this packet (after you have submitted your application and received your Humana member ID card).

You don’t need to use this consent form to authorize an individual if you are also submitting a POA or other legal authorization for the same individual.

* If you have previously submitted a consent form for this individual, you do not need to submit again at this time. We will notify you if your consent is due to expire.

Humana.

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# Consent for release of protected health information

**Member information** (person whose information will be released):

Name: _____ Date of birth: ____ / ____ / ____
First Middle Last Month Day Year

Address: _____
Street City State Zip

Member ID: _____ Group # (if applicable): _____ Phone #: _____ ☐ Home ☐ Cell*

**Complete the following only if the person making the request is not the member**

Name of Requestor: _____ Address: _____

Relationship to Member: _____ Legal Authority: _____ Phone #: _____ ☐ Home ☐ Cell*

**I understand that this authorization will allow Humana and its affiliates to use or disclose the protected health† information (PHI) described below:** (Please check only **one** box)

☐ **Full Disclosure:** Any protected health information Humana and its affiliates maintain, including sensitive health information as listed below. This also includes sharing information on prescription drug/medication data, wellness products, and health programs with the person being authorized.

☐ **Excluded Sensitive Health Disclosures**: All protected identified above except for the categories selected below. If no items are checked, all information will be selected. Please check all that apply:

- ☐ Behavioral or Mental Health
- ☐ Sexually Transmitted Disease/HIV/AIDS
- ☐ Infectious diseases
- ☐ Genetic Data
- ☐ Reproductive Health
- ☐ Substance Use disorder, subject to 42 CFR Part 2

☐ **Limited Disclosure**: You specify what PHI to share, e.g., condition or treatment information, a specific date range, or product type. Unless you limit by product type, information will apply to all products and services.

If Limited Disclosure was selected, please indicate which product(s) apply:

☐ **Medical** ☐ **Vision** ☐ **Dental** ☐ **Prescription Drug/Medication Data** ☐ **Go365®**

This information may be disclosed to, and used by, the following person or organization to assist me with the Humana-owned products or services for which I am providing consent to disclose information:

Name: _____ Date of birth: ____ / ____ / ____
First Middle Last *Required Field* Month Day Year

Or Organization Name (such as nursing home, care provider or care manager): _____

Address: _____
Street City State Zip

Email: _____ Phone #: _____ ☐ Home ☐ Cell*

Relationship: ☐ Spouse ☐ Sibling ☐ Parent ☐ Child ☐ Agent/Broker ☐ Friend ☐ Organization

I understand:

- I am not required to fill out this consent and Humana cannot base decisions regarding treatment, payment, enrollment or eligibility for benefits on whether I submit it.
- Disclosures may include information from past, present, and/or future treating providers.
- This consent is valid until I cancel my Humana membership. For customers in certain states consents will expire in compliance with applicable state laws.‡ I can cancel my consent at any time through my MyHumana account, by calling customer service, or by submitting a written notice to Humana.
- If I cancel consent, it will not apply to any information previously released with this authorization. Once information is shared, Humana cannot prevent the person or organization who has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.

Member or Legal Representative signature _____ Date: ____ ____ ____

**Please note: Legal representatives must attach copies of authorization as required by law. Examples include healthcare power of attorney, healthcare surrogate, living will or guardianship papers.**

After you complete and sign the form, please fax it to **800-633-8188.** Or, if you prefer, mail your completed form to:
**Humana Insurance Company, P.O. Box 14168, Lexington, KY 40512-4168**

* By giving your cell phone number, you give Humana permission to make calls related to this authorization to your cell.

† Health includes Medical, Dental, Pharmacy, Behavioral Health, Vision, Long-Term Care.

‡ Expires in 12 months: CA, CT, GA, IL, MA, MD, NC, NJ, NV, OH, OR
Expires in 24 months: FL, KY, MT, VA & Puerto Rico

Humana®



Humana will follow the more stringent of all federal and state laws and regulations.

For Humana Use Only

# Important

## At Humana, it is important you are treated fairly.

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

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **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, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents**: You may also call California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

## Auxiliary aids and services, free of charge, are available to you. 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.

## Language assistance services, free of charge, are available to you. 877-320-1235 (TTY: 711)

**Español (Spanish):** Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
**繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。
**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
**Русский (Russian):** Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
**Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
**Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.
**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 **(Japanese)**: 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
**فارسی (Farsi)**

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
**Diné Bizaad ËNavajoЂ:** W0dah7 b44sh bee hani'7 bee wolta'7g77 bich'9' h0d77lnih 47 bee t'11 jiik'eh saad bee 1k1'1n7da'1wo'd66 nik1'adoowo[.
**العربية (Arabic)**

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

# Scope of Appointment form

It's important for you to understand the type of health product(s) that you can choose to discuss before your appointment with a licensed Humana sales agent. The Centers for Medicare & Medicaid Services (CMS) requires sales agents to document the scope of any personal marketing appointment. All information provided on this form is confidential, and a separate form should be completed by each beneficiary who wishes to discuss plan options or by their legally authorized representative. We look forward to speaking with you.

The licensed sales agent who will discuss the plan options with you is either employed or contracted by a Medicare plan. They do not work for the federal government. This licensed sales agent may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment status, or automatically enroll you in a Medicare plan.

## Medicare Advantage plans (Part C)

A Medicare Advantage (MA) plan provides all Original Medicare Part A and Part B health coverage and sometimes offers Part D prescription drug (MAPD) coverage and other additional benefits. There are different types of MA plans, such as:

**Health maintenance organization (HMO) plan**
This type of MA plan typically requires you to see only in-network providers and, on many plans, you do not need a referral from your primary care physician (PCP)* to see a specialist.

**Preferred provider organization (PPO) plan**
This type of MA plan gives you the freedom to get care in or out of network. In most cases, you'll pay less if you use in-network providers. Referrals to see a specialist are not required.

**Private fee-for-service (PFFS) plan**
On this type of MA plan, you may go to almost any Medicare-approved doctor, hospital or provider that accepts the plan's payment, accepts the terms and conditions and agrees to treat you.

**Special Needs Plan (SNP)**
This type of MA plan has a benefits package designed for people with special healthcare needs. Examples of groups served include people who have both Medicare and Medicaid, reside in long-term care facilities and/or have been diagnosed with an eligible chronic condition.

## Stand-alone Medicare prescription drug plans (Part D)

**Medicare prescription drug plans (PDP)**
This stand-alone drug plan adds prescription drug coverage to Original Medicare and some other Medicare plans.

## Other products

**Medicare Supplement insurance plans**
Medicare Supplement plans are standardized plans that can be bought with varying coverage options to help supplement your Original Medicare coverage. While an MA plan takes the place of Original Medicare, a Medicare Supplement plan is simply added to Original Medicare. Medicare Supplement plans have no provider networks and help pay some of the costs that Original Medicare does not pay. Medicare Supplement plans will not provide coverage when enrolled in a Medicare Advantage plan.

**Dental plans**
Stand-alone dental plans are available at varying levels of coverage at in- and out-of-network providers.

**Vision plans**
Stand-alone vision plans are available at varying levels of coverage at in- and out-of-network providers.

**Hospital Indemnity plans**
Hospital Indemnity plans cover some of the costs associated with hospital stays that may not be covered by a primary health plan.

* This information is provided for educational purposes only. It is not to be used for medical advice, diagnosis or treatment. Consult your healthcare provider if you have questions or concerns.

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# Scope of Appointment

**In the space provided below, please initial next to the type of health product(s) you want the licensed sales agent to discuss.**

| | |
|---|---|
| ☐ Medicare Advantage plans (Part C) | ☐ Dental plans |
| ☐ Stand-alone prescription drug plans (Part D) | ☐ Vision plans |
| ☐ Medicare Supplement plans | ☐ Hospital Indemnity plans |

Name _____ Phone _____

Address (Street, City, State ZIP code) _____ Relationship to the beneficiary _____

_____ Medicare ID number (optional) _____

**By signing this form, you are agreeing to a sales meeting with a sales agent to discuss the specific types of products you initialed above. The person who will be discussing plan options with you is either employed or contracted by a Medicare health plan or prescription drug plan that is not the federal government, and they may be compensated based on your enrollment in a plan.**

**Signing this form does NOT affect your current enrollment, nor will it enroll you in a Medicare Advantage plan, prescription drug plan or other Medicare plan.**

Beneficiary or legally authorized representative signature and signature date**:**

Signature _____ Signature date _____/_____/_____

**To be completed by agent:** (Please print)

Agent name _____

Agent phone _____

Agent SAN _____

**Agent please mail this form to:**
MarketPoint
P.O. Box 14637
Lexington, KY 40512-4637
Or fax to: **877-889-9936**

Initial method of contact: _____

Date and time of form completion:

____/____/____, ____:____ [ ] a.m. [ ] p.m.

Date and time of scheduled appointment:

____/____/____, ____:____ [ ] a.m. [ ] p.m.

Agent signature _____ Agent signature date _____/_____/_____

Plan(s) the agent represented _____

Application number or recording ID _____

Date appointment completed _____/_____/_____

Scope of Appointment documentation is subject to CMS record retention requirements.

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# Your licensed sales agent can walk you through **3 easy ways to enroll**

**Go online** to **Humana.com/Medicare** to shop for a plan and enroll.

**Scan the QR code** with your phone or tablet's camera or go to **Huma.na/27appGNHHUTSEN** to view and print the enrollment form.

**Get an enrollment form from your agent.**

## Thinking about adding separate coverage for dental, vision or hearing?

Talk to your licensed sales agent about what's covered in your Medicare Advantage plan. You may want to discuss your options for purchasing a separate non-Medicare plan with an additional premium to add coverage for dental, vision or hearing.

Humana offers individual dental or vision plans as well as combined dental, vision and hearing plans. Adding a separate plan is not required.*

- For more information on dental plans, visit: **Humana.com/dental**
- For more information on vision plans, visit: **Humana.com/vision**
- For more information on plans that combine these benefits, visit: **Humana.com/dental-vision-hearing**

* Plans are not available in all states. Plan benefits may vary by state. Refer to the plan documents for complete details of coverage. Dental and vision plans, excluding Dental Savings Plus, may have a minimum one-year initial contract period. Payment may include an administration fee. Association membership and fees may be required on some plans in some states. A one-time, non-refundable enrollment fee may apply (the fee is non-refundable as allowed by state requirements). Applicable fees are disclosed at time of enrollment. These are not Medicare plans. For Arizona: This is a solicitation of insurance. A licensed insurance agent/producer may contact you. For Texas: An invitation to inquire must include the following information: that the age or gender on which that rate is based (or in the case of IDV, neither age nor gender are used as a basis for the rates); that the rates are illustrative only; that a person should not send money to the issuer in response to the advertisement; and that a person cannot obtain coverage under the health benefit plan without completing application for coverage.

This communication provides a general description of certain identified insurance or non-insurance benefits provided under one or more of our insurance benefit plans. Our insurance benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, refer to the plan document or call or write your Humana insurance agent or the company. In the event of any disagreement between this communication and the plan document, the plan document will control.

# Receipt of Enrollment form

Completion of this form signifies the receipt of enrollment in a Humana Medicare plan. Note: Enrollment is pending review and final approval by the Centers for Medicare & Medicaid Services (CMS) and Humana. Humana will send a letter once processing is complete. You may use this form as temporary proof of coverage until you receive your Humana member ID card. Please note, however, that if the application is not approved, claims may be denied and you may be responsible for the cost of services you receive.

Member name

Humana licensed sales agent name / phone number

Application ID number

Plan name

Plan type

Proposed effective date

Primary care provider (PCP)

PCP phone number (if applicable)

Plan premium _____ Copayment: PCP _____ Specialist _____ ER _____

❑ I have read and reviewed the Summary of Benefits.

**Optional supplemental benefits (OSB) you are enrolling in (if applicable):**

**Please refer to the information below regarding the plan you have applied for until you receive your Humana member ID card.**

| | |
|---|---|
| Medicare Advantage prescription drug (MAPD) plans or prescription drug plans (PDP) (Part D) | PCN: 03200000 |
| | BIN: 015581 |
| Medicare Advantage (MA) plans (without drug coverage) | PCN: 03200004 |
| | BIN: 610649 |

RX plan – _____ – _____

Processor control number (PCN) Bank identification number (BIN)

_____ – _____ _____

Contract – Plan benefit package (PBP) Segment

_____ _____ _____ _____

Member signature Date Agent signature Date

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**Humana Customer Care**
For questions about claims, benefits or anything else regarding your Humana coverage, visit **Humana.com/Help** or call **800-457-4708 (TTY: 711)**.

| **Oct. 1 – Mar. 31** | **Apr. 1 – Sept. 30** |
|---|---|
| Daily | Monday – Friday |
| 8 a.m. – 8 p.m. | 8 a.m. – 8 p.m. |

**24-hour medical service authorization: 800-523-0023 (TTY: 711)**

Doctor and hospital: Health maintenance organization (HMO) and preferred provider organization (PPO) plans require authorization for all nonemergency and nonurgent services. Notification is requested for private fee-for-service (PFFS) plans. Providers can call **800-457-4708** for PFFS plan terms and conditions.

Humana MyOption optional supplemental benefits (OSB) are only available to members of certain Humana Medicare Advantage (MA) plans. Members of Humana plans that offer OSBs may enroll in OSBs at the time of initial enrollment in the MA plan or within 3 months after the plan's effective date. Benefits may change on January 1 each year.

Enrollees must continue to pay the Medicare Part B premium, their Humana plan premium, and the OSB premium.

# IMPORTANT INFORMATION:

## 2026 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Humana - H7617

**For 2026, Humana - H7617 received the following Star Ratings from Medicare:**

| | |
|---|---|
| **Overall Star Rating:** | ★★★★½ |
| **Health Services Rating:** | ★★★★½ |
| **Drug Services Rating:** | ★★★★☆ |

**Every year, Medicare evaluates plans based on a 5-star rating system.**

### Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

**The number of stars show how well a plan performs.**

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

### Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at Medicare.gov/plan-compare.

### Questions about this plan?

Contact Humana 7 days a week from 8:00 a.m. to 8:00 p.m. local time at 888-873-0686 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. local time. Current members please call 800-457-4708 (toll-free) or 711 (TTY).

# Resources guide

**MyHumana**
View your plan benefits, coverage details, and digital ID card.
**MyHumana.com**

**Find Care**
Get help finding a doctor or other care provider. Use our Find Care tool.
**Humana.com/FindCare**

**Home healthcare services**
If the plan you choose has home healthcare services, you can get access to care in your home.
**Humana.com/Home-Care**

**Virtual visits**
If the plan you choose has virtual visits, you can connect with a doctor via an internet-enabled device to receive care.
**Humana.com/VirtualVisits**

**Supplemental dental benefits**
If the plan you choose has embedded dental benefits, you can check the DENxxx benefit description to see what's covered.*
**Humana.com/SB**

**Humana Community Navigator®**
Connect to free or low-cost community services, such as utilities, food aid, housing support, transportation and more.
**Humana.findhelp.com**

**Go365 by Humana®**
If the plan you choose has Go365 by Humana®, you can earn rewards by completing healthy activities.†
**MyHumana.com**

**Dental, vision or hearing**
Explore individual dental or vision plans, or combined dental, vision and hearing plans for added coverage.
**Humana.com/Dental**

**Pharmacy**
Find retail and mail-order pharmacies.
**Humana.com/Pharmacy**

**Humana Customer Care**
For questions about claims, benefits or anything else about your Humana coverage, visit **Humana.com/Help** or call **855-391-8662 (TTY: 711)**.

Oct. 1 – Mar. 31: Daily, 8 a.m. – 8 p.m.

Apr. 1 – Sept. 30: Monday – Friday, 8 a.m. – 8 p.m.

Not all benefits and resources listed are available on all plans or in all areas. Consult your Evidence of Coverage or ask your licensed sales agent to find out what benefits are included in this plan.

* Prospects without an ID card can locate the DENxxx associated with their plan in the Summary of Benefits and in the Evidence of Coverage.

† Go365 is not an insurance product and is not available with all Humana health plans. This is a general description of services which are subject to change. Product features may vary by client. Please refer to Customer Support for more information. Rewards must be earned and redeemed within the same plan year. Rewards not redeemed before Dec. 31st will be forfeited.

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

Other pharmacies/physicians/providers are available in the Humana network.

Humana is a Medicare Advantage HMO, PPO, and PFFS organization with a Medicare contract. Enrollment in any Humana plan depends on contract renewal.

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

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

This communication provides a general description of certain identified insurance or non-insurance benefits provided under one or more of our insurance benefit plans. Our insurance benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, refer to the plan document or call or write your Humana insurance agent or the company. In the event of any disagreement between this communication and the plan document, the plan document will control.