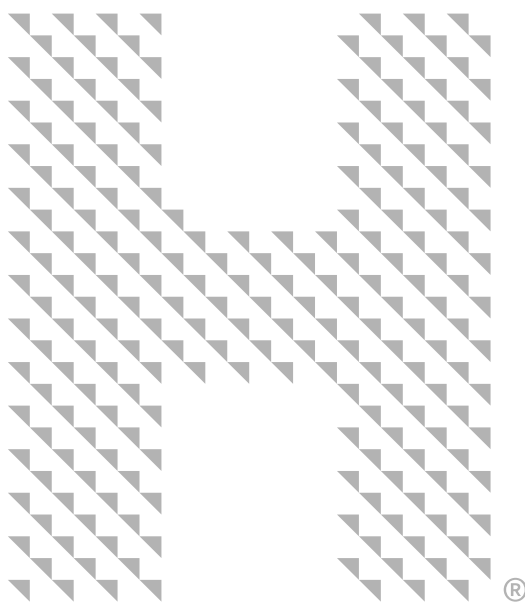


PPO

HumanaChoice Giveback
H7617-014-000
Select Counties in MO
H7617014000MAPDEN26PODPPPOF

MO: Barry, Barton, Cape Girardeau, Cedar, Christian, Dade, Dallas, Douglas, Greene, Hickory, Howell, Jasper, Laclede, Lawrence, McDonald, Newton, Oregon, Ozark, Polk, Pulaski, Scott, St. Clair, Stone, Taney, Vernon, Webster, Wright



Enrollment book

2026 MAPD

**Medicare Advantage
Prescription Drug Plan**

The care you deserve

so you can focus on your health

Humana®

Humana®

2026 MAPD

Being in tune with you and delivering what you need

Being a Humana member means having benefits that go beyond Original Medicare—with access to trusted networks and care. We listen to what you need and bring you guidance and support to help you on your journey to feel your best. Your Medicare Advantage prescription drug (MAPD) plan may have additional benefits beyond the ones listed here, so check your Summary of Benefits.

Here's how we help you reach your health goals:



Multiple large plan networks of **doctors, hospitals and pharmacies**



May include **dental, vision, and hearing** coverage



All-in-one plans with prescription drug coverage and an annual cap on your out-of-pocket costs for covered medical services.



Resources at your fingertips with our simple **digital tools** like MyHumana



Dedicated **Customer Care team** ready to answer questions and provide support

Decades of experience, at your service

Humana has been in healthcare for over 60 years. We serve millions of members through our plan benefits, competitive premiums, and support that help you feel your best, head to toe. How? We call it human care. It's all the ways we get to know you—and how we aim to go above and beyond to bring you more than you might expect from a health plan.



Get connected to resources in your community like utility services, food assistance, housing support, transportation programs, and more at

Humana.FindHelp.com

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.



What's inside

H7617-014-000

- ☒ **How this plan works**
- ☒ **Understanding your Medicare options**
- ☒ **What's next after you enroll**
- ☒ **Summary of Benefits**
- ☒ **Enrollment documents**
- ☒ **Important resources guide**

Your agent information

Agent name _____

Agent phone number _____

Agent email _____



Let's talk

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

Humana.

How this plan works

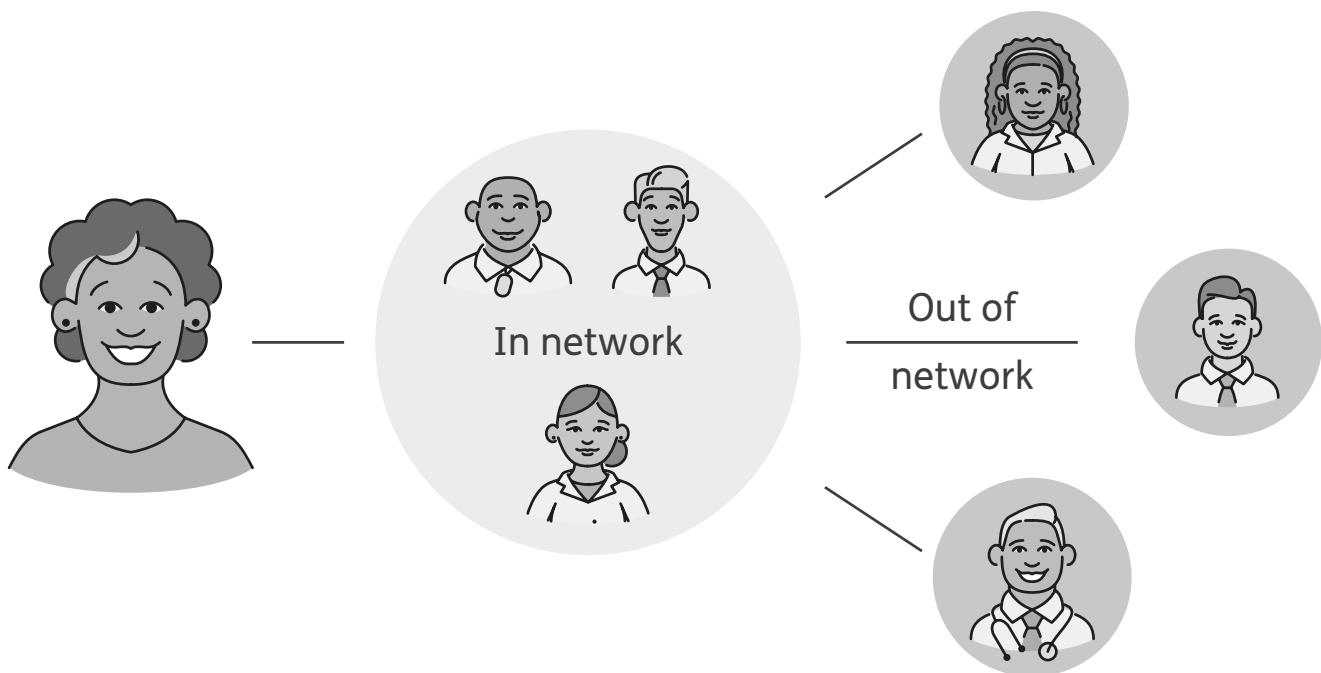
Here's how a PPO Medicare Advantage plan would work. (See all your Medicare options on the following page.)

Preferred provider organization

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

Using a PPO plan

- In-network providers cost less: these doctors and hospitals partner with your plan, so you may pay less for copays, coinsurance, and more.
- There may be higher cost sharing or no coverage from the plan if you receive 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.



Understanding 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

Option 2: Add one or more of the following to Original Medicare.



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 coverage.



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



Medicare Part D is a stand-alone prescription drug plan.†



Medicare Supplement insurance (Medigap) plans help pay for some of Original Medicare's out-of-pocket costs for covered medical services.



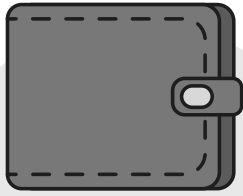
Individual dental and vision plans or combined dental, vision and hearing plans can help ensure coverage for all your healthcare needs.*

* 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: A person should not send money to the issuer in response to the advertisement and a person cannot obtain coverage under the health benefit plan without completing application for coverage.

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

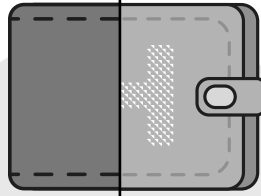
Understanding the Part D Prescription Drug Stages



STAGE 1

Deductible: **you pay 100%**

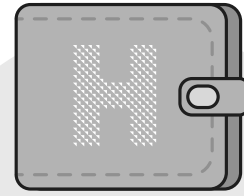
- A deductible is the amount you pay for your covered prescription drugs before the plan pays its share — you pay all costs until the deductible is met.
- Some plans may not have a deductible, allowing you to enter Stage 2 upon filling your first prescription of the year.
- Deductible amounts and tier exclusions vary across plans – many plans exclude commonly used medications from the Deductible Stage.



STAGE 2

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

- During the Initial Coverage Stage, 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 \$2,100.



STAGE 3

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

- During the Catastrophic Coverage Stage, you pay nothing for the remainder of the calendar year.
- The plan is responsible for the full cost for your covered Part D prescription drugs.

What's next after you enroll

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



A notice confirming your application is approved



Your Humana member ID card

As a Humana member, you'll have access to MyHumana. It's your secure online account where you will be able to set up a personal profile to see your coverage details, check claims, compare drug prices, find in-network providers and more. If you download the MyHumana mobile app for iOS or Android, you can manage your plan anytime, anywhere.

Get this information in your MyHumana account:

- Summary of Benefits—the value-added items and services that may be available with this plan
- Annual Notice of Change
- SmartSummary® (Explanation of Benefits)
- Health and wellness information
- Plan messages and notifications (verification of enrollment, confirmation of enrollment)
- Medication information and resources



Go to **Humana.com/LogOn** to set up your secure MyHumana account. Verifying your identity and updating your communication preferences is simple and easy.



Get health and wellness items you need

with the **Humana over-the-counter mail-order allowance**

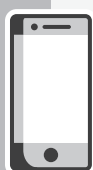
Save trips to the store with the over-the-counter (OTC) mail-order allowance included in this plan. You can use your allowance at CenterWell Pharmacy® to buy eligible OTC health and wellness products when you need them throughout the year.*

The CenterWell Pharmacy online OTC catalog offers a selection of products to choose from—shop online and have your items mailed right to your door. Visit **Huma.na/aboutotc** to learn more about how to order through CenterWell Pharmacy.



Order hundreds of OTC products, including:

- Allergy medicine
- Antacid heartburn relievers
- Aspirin
- Bandages
- Cough suppressants and expectorants
- Denture cleaners
- Multivitamins
- OTC hearing aids
- Pain relievers
- Sunscreen



Visit **Huma.na/docs-forms** or scan the QR code with your smartphone or tablet's camera to view or print the current OTC Health and Wellness Products catalog and order form. The 2026 OTC catalog and order form will be available Jan. 1, 2026.



If you have questions or to find out this plan's OTC mail-order allowance, check the Summary of Benefits or ask your licensed sales agent.

If you do not have the ability to access the online catalog and need to request a printed catalog from CenterWell Pharmacy, please call **855-211-8370 (TTY: 711)** after Jan. 1, 2026.



* Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply. If you have questions about how to use the OTC allowance at CenterWell Pharmacy, call **855-211-8370 (TTY: 711)**. CenterWell Pharmacy Customer Care specialists are available Monday – Friday, 8 a.m. – 11 p.m., and Saturday, 8 a.m. – 6:30 p.m., Eastern time.

OTC items may only be purchased for the plan enrollee. It is prohibited to purchase OTC items for family members and friends. Purchase of covered OTC products made under emergency circumstances may be eligible for reimbursement when the benefit allowance is available. Please check with your healthcare provider before using any of the OTC products offered.

Humana is a Medicare Advantage HMO, PPO, and PFFS organization with a Medicare contract. Humana is also a Dual Eligible Special Needs HMO SNP, PPO SNP plan with a Medicare contract and a contract with the state Medicaid program. Enrollment in any Humana plan depends on contract renewal.

Sponsored by Humana Medical Plan, Inc. and the State of Florida, Agency For Health Care Administration.

Humana is a DSNP with a Florida Medicaid Contract. The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the DSNP. Limitations, copayments and/or restrictions may apply. Benefits and pharmacy network may change.

NOTICE: TennCare is not responsible for payment for these benefits, except for appropriate cost sharing amounts. TennCare is not responsible for guaranteeing the availability or quality of these benefits. Any reference to more, extra, or additional Medicare benefits, is applicable to Medicare only and does not indicate increased Medicaid benefits.

Summary of Benefits

HumanaChoice Giveback H7617-014 (PPO)

Missouri

Select counties in Missouri

Our service area includes the following county/counties in Missouri: Barry, Barton, Cape Girardeau, Cedar, Christian, Dade, Dallas, Douglas, Greene, Hickory, Howell, Jasper, Laclede, Lawrence, McDonald, Newton, Oregon, Ozark, Polk, Pulaski, Scott, St. Clair, Stone, Taney, Vernon, Webster, Wright.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **800-833-2364 (TTY: 711)**.

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 **800-833-2364 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary (Drug Guide) to make sure your drugs are covered.

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, 2027.
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ This plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copay/coinsurance for services received by non-contracted providers.



Let's talk about HumanaChoice Giveback H7617-014 (PPO)

Find out more about the HumanaChoice Giveback H7617-014 (PPO) plan – including the health and drug services it covers – in this easy-to-use booklet.

HumanaChoice Giveback H7617-014 (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/PlanDocuments](https://www.humana.com/PlanDocuments)**.

To be eligible

To join HumanaChoice Giveback H7617-014 (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name

HumanaChoice Giveback H7617-014 (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: **800-833-2364 (TTY: 711)**.

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

[Humana.com/Medicare](https://www.humana.com/Medicare)

More about HumanaChoice Giveback H7617-014 (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). HumanaChoice Giveback H7617-014 (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 You must keep paying your Medicare Part B premium.
Part B premium reduction¹	Your plan will reduce your Monthly Part B premium by up to \$71 but by no more than Original Medicare's Part B Premium for 2026.
Medical deductible	\$500 combined The following services listed are excluded from the combined in-network and out-of-network deductible: In-Network only: Ambulance Services Chemotherapy Drugs and Administration Continuous Glucose Monitor Diabetic Monitoring Supplies Diagnostic Colonoscopy Diagnostic Mammography Durable Medical Equipment Lab Services Other Medicare Part B Drugs Outpatient Blood Services Primary Care Physician's Office Specialist's Office Both In-Network and Out-of-Network: Emergency Room Services Medicare Covered Preventive Services Medicare Part B Insulin Drugs Services not covered by Original Medicare (i.e., Supplemental Benefits) Urgently Needed Services at Urgent Care Centers
Pharmacy (Part D) deductible	\$0 deductible for Tier 1, Tier 2 and Tier 3 \$615 deductible for Tier 4 and Tier 5
Medical Maximum out-of-pocket responsibility	\$5,500 in-network \$10,100 combined in- and out-of-network The most you pay for copays, coinsurance and other costs for covered medical services for the year.

¹It could take several months for the Social Security Administration to complete their processing. This means you may not see the increase in your Social Security check for several months 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](https://www.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 \$0 copay per day for days 6-90	50% of the cost
OUTPATIENT HOSPITAL COVERAGE		
Diagnostic colonoscopy	\$0 copay	\$0 copay
Diagnostic mammography	\$0 copay	\$0 copay
Surgery services	\$300 copay	50% of the cost
AMBULATORY SURGERY CENTER		
Diagnostic colonoscopy	\$0 copay	\$0 copay
Surgery services	\$200 copay	50% of the cost
DOCTOR VISITS		
Primary care provider (PCP)		
• PCP's office	\$0 copay	45% of the cost
• Telehealth	\$0 copay	Not Covered
Specialist		
• Specialist's office	\$45 copay	50% of the cost
• Telehealth	\$45 copay	Not Covered
PREVENTIVE CARE		
This plan covers all Medicare preventive services including:	\$0 copay	\$0 copay or 50% of the cost, depending on the service and where service is provided.
Cancer Screenings		
• Breast cancer screening (mammogram)		
• Cervical and vaginal cancer screening		
• Colorectal cancer screening		
• Lung cancer screening		
• Prostate cancer screening		
Cardiovascular (heart) Care		
• Abdominal aortic aneurysm screening		
• Cardiovascular disease risk reduction visit		
• Cardiovascular disease screenings		

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



IN-NETWORK

OUT-OF-NETWORK

Diabetes Care

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

Dietary Guidance and Support

- Medical nutrition therapy
- Obesity screening and therapy

Routine Screenings and Immunizations

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

Screenings and Counseling Services

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

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

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

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Medical Benefits (cont.)

H7617014000

	IN-NETWORK	OUT-OF-NETWORK
EMERGENCY CARE		
Emergency services at emergency room If you are admitted to the same hospital within 24 hours for the same condition, you pay \$0 for the emergency care you received. We cover emergency services worldwide. If you have an emergency outside of the U.S. and its territories, you will be responsible to pay for the rendered service(s) upfront and can request reimbursement. When placed in observation, member pays observation cost-share instead of emergency room cost-share.	\$130 copay	\$130 copay
URGENTLY NEEDED SERVICES		
• Telehealth • Urgent care center Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical attention. We cover urgently needed services worldwide. If you have an urgently needed service outside of the U.S. and its territories, you will be responsible to pay for the rendered service(s) upfront and can request reimbursement.	\$50 copay \$50 copay	Not Covered \$50 copay

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](https://www.humana.com/PAL)**.



Medical Benefits (cont.)

H7617014000

	IN-NETWORK	OUT-OF-NETWORK
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Advanced imaging services (MRI, MRA, PET and CT scans)		
• Freestanding radiological facility	\$200 copay	50% of the cost
• Outpatient hospital	\$335 copay	50% of the cost
• PCP's office	\$280 copay	50% of the cost
• Specialist's office	\$280 copay	50% of the cost
Basic radiological services (X-rays)		
• Freestanding radiological facility	\$65 copay	50% of the cost
• Outpatient hospital	\$150 copay	50% of the cost
• PCP's office	\$0 copay	45% of the cost
• Specialist's office	\$45 copay	45% of the cost
• Urgent care center	\$50 copay	45% of the cost
Diagnostic mammography		
• Freestanding radiological facility	\$0 copay	\$0 copay
• Specialist's office	\$0 copay	\$0 copay
Diagnostic procedures and tests		
• Outpatient hospital	\$35 copay	50% of the cost
• PCP's office	\$0 copay	45% of the cost
• Specialist's office	\$45 copay	50% of the cost
• Urgent care center	\$50 copay	50% of the cost
Lab services		
• Freestanding laboratory	\$5 copay	50% of the cost
• Outpatient hospital	\$10 copay	50% of the cost
• PCP's office	\$0 copay	50% of the cost
• Specialist's office	\$0 copay	50% of the cost
• Urgent care center	\$0 copay	50% of the cost
Nuclear medicine and services		
• Freestanding radiological facility	\$245 copay	50% of the cost
• Outpatient hospital	\$250 copay	50% of the cost
Sleep study		
• Member's home	\$0 copay	50% of the cost
• Outpatient hospital	20% of the cost	50% of the cost
• Specialist's office	\$45 copay	50% of the cost

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

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Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Therapeutic radiology (Radiation therapy)		
• Freestanding radiological facility	\$50 copay	50% of the cost
• Outpatient hospital	\$50 copay	50% of the cost
• Specialist's office	\$30 copay	45% of the cost
 HEARING SERVICES		
Medicare-covered hearing	\$45 copay	50% of the cost
Mandatory supplemental hearing benefit	HER965 • \$0 copay for routine hearing exams up to 1 per year. • \$199 copay for each Standard level hearing aid up to 1 per ear per year. • \$499 copay for each Advanced level hearing aid up to 1 per ear per year. • \$799 copay for each Premium level hearing aid up to 1 per ear per year. Hearing aid purchase includes: • Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models • Rechargeable style options available for Premium and Advanced aids for an additional \$50 per aid You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (TTY: 711).	Hearing aids must be purchased through TruHearing. Coverage will not be provided for hearing aids purchased from a non-participating provider.

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



Medical Benefits (cont.)

IN-NETWORK

OUT-OF-NETWORK



DENTAL SERVICES

Medicare-covered dental

\$45 copay

50% of the cost

Mandatory supplemental dental benefit

Limitations and exclusions may apply. Please see your Evidence of Coverage (EOC) for additional details. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. Dental benefits under this plan may not cover all ADA procedure codes. Any services received that are not listed will not be covered by the plan and will be the member's responsibility. The member is responsible for any amount above the annual maximum benefit coverage amount. Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. Information regarding each plan is available at **Humana.com/sb**.

In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule (but any applicable coinsurance payment still applies). Visiting an in-network provider may result in

DENB34

- **\$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.
- **\$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years.
- **\$0** copay for bridge recementation, crown recementation, panoramic film or diagnostic x-rays up to 1 every 5 years.
- **\$0** copay for crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime.
- **\$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.
- **\$0** copay for adjustments to dentures, denture rebase, denture relines, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year.
- **\$0** copay for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.
- **\$0** copay for periodontal maintenance up to 4 per year.

DENB34

- **\$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.
- **\$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years.
- **\$0** copay for bridge recementation, crown recementation, panoramic film or diagnostic x-rays up to 1 every 5 years.
- **\$0** copay for crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime.
- **\$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.
- **\$0** copay for adjustments to dentures, denture rebase, denture relines, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year.
- **\$0** copay for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.
- **\$0** copay for periodontal maintenance up to 4 per year.

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

Humana.



Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
significant savings. The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator for our nationwide network can be found at Humana.com/FindCare. Out-of-network dentists have not agreed to provide services at contracted fees. The out-of-network provider may bill the member for more 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. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Members may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Please see above for provider locator instructions. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement. The coinsurance level will apply to the average negotiated in-network fee schedule (INFS) in your area. See Chapter 2 Payment Requests Contact Information in your	• \$0 copay for necessary anesthesia with covered service up to as needed with covered codes per year. • \$0 copay for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year. • 30% of the cost for bridges-pontic, complete dentures, partial dentures up to 1 every 5 years. • 30% of the cost for bridges-crown up to 2 every 5 years. • \$4,000 combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.	• \$0 copay for necessary anesthesia with covered service up to as needed with covered codes per year. • \$0 copay for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year. • 30% of the cost for bridges-pontic, complete dentures, partial dentures up to 1 every 5 years. • 30% of the cost for bridges-crown up to 2 every 5 years. • \$4,000 combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

*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

Evidence of Coverage or visit **Humana.com** for information on requesting reimbursement.



VISION SERVICES

	IN-NETWORK	OUT-OF-NETWORK
Eyewear (post cataract surgery)	\$0 copay	50% of the cost
Medicare-covered diabetic eye exam	\$0 copay	50% of the cost
Medicare-covered vision services The provider locator for Medicare-covered vision can be found at Humana.com/FindCare .	\$45 copay	50% of the cost
Mandatory supplemental vision benefit Please inform the network provider that you are part of the Humana Medicare Insight Network. NOTE: The network of providers for your supplemental vision benefits through Humana Medicare Insight Network may be different than the network of providers for the Medicare-covered vision benefits. The provider locator can be found at Humana.com/FindCare . Benefit allowance is applied toward the retail price. Member is responsible for any costs above the plan approved amount. Lost or broken materials are not covered. This benefit is limited to a one-time use per year. Any remaining benefit dollars do not "roll over" to a future purchase. Eyeglass lens options may be available with the maximum	VIS694 • \$0 copay for routine exam up to 1 per year. • \$75 combined maximum benefit coverage amount per year for routine exam. • \$50 maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • OR • \$100 maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year.	VIS694 • \$0 copay for routine exam up to 1 per year. • \$75 combined maximum benefit coverage amount per year for routine exam. • \$50 maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. • Maximum benefit coverage amounts cannot be combined.

Mandatory supplemental vision benefit

Please inform the network provider that you are part of the Humana Medicare Insight Network. NOTE: The network of providers for your supplemental vision benefits through Humana Medicare Insight Network may be different than the network of providers for the Medicare-covered vision benefits. The provider locator can be found at **Humana.com/FindCare**.

Benefit allowance is applied toward the retail price. Member is responsible for any costs above the plan approved amount. Lost or broken materials are not covered.

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

VIS694

- **\$0** copay for routine exam up to 1 per year.
- **\$75** combined maximum benefit coverage amount per year for routine exam.
- **\$50** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.
- OR
- **\$100** maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.
- Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year.
- Maximum benefit coverage amount is limited to one time use per year.

VIS694

- **\$0** copay for routine exam up to 1 per year.
- **\$75** combined maximum benefit coverage amount per year for routine exam.
- **\$50** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.
- Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year.
- Maximum benefit coverage amount is limited to one time use per year.
- Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
- Maximum benefit coverage amounts cannot be combined.

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

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Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
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.	Maximum benefit coverage amounts cannot be combined. 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 .	
MENTAL HEALTH SERVICES		
Inpatient 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 1-5 \$0 copay per day for days 6-90	50% of the cost
Mental health therapy visits - Outpatient hospital - Specialist's office - Telehealth	\$35 copay \$30 copay \$30 copay	50% of the cost 50% of the cost Not Covered
Outpatient substance abuse services - Outpatient hospital - Specialist's office - Telehealth	\$35 copay \$30 copay \$30 copay	50% of the cost 50% of the cost Not Covered
SKILLED NURSING FACILITY (SNF)		
This plan covers up to 100 days in a SNF	\$10 copay per day for days 1-20 \$218 copay per day for days 21-100	50% of the cost for days 1-100
AMBULANCE		
Air	20% of the cost	20% of the cost
Ground	\$335 copay per date of service	\$335 copay per date of service
TRANSPORTATION		
	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.)

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IN-NETWORK

OUT-OF-NETWORK

MEDICARE PART B DRUGS

Some rebatable Part B drugs may be subject to a lower coinsurance.

Allergy shots and serum

• PCP's office	\$0 copay	50% of the cost
• Specialist's office	\$25 copay	50% of the cost

Chemotherapy drugs

• Outpatient hospital	20% of the cost	50% of the cost
• Specialist's office	20% of the cost	50% of the cost

Other Part B drugs

• Outpatient hospital	20% of the cost	50% of the cost
• PCP's office	20% of the cost	50% of the cost
• Pharmacy	20% of the cost	50% of the cost
• Specialist's office	20% of the cost	50% of the cost

Part B Insulin

• Outpatient hospital	20% of the cost	50% of the cost
• PCP's office	20% of the cost	50% of the cost
• Pharmacy	20% of the cost	50% of the cost
• Specialist's office	20% of the cost	50% 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](https://www.humana.com/PAL)**.

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 Prescription Drug Benefits

PLAN HIGHLIGHTS

\$0 copays	\$0 copays at select pharmacy locations and tiers. Additional details below.
Deductible	\$0 deductible for Tier 1, Tier 2 and Tier 3
Insulin costs	You won't pay more than \$35 for a one-month (up to 30-day) supply of each insulin product covered by this plan.
100-day supply	Up to 100-day supply on eligible drugs
Excluded drug coverage	Additional drug coverage for the following: Erectile dysfunction (ED) drugs Prescription vitamins
\$0 vaccines	\$0 copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

DEDUCTIBLE

\$0 deductible for Tier 1, Tier 2 and Tier 3. This plan has a **\$615** deductible for Tier 4 and Tier 5 drugs. You pay the full cost of these drugs until you reach **\$615**. Then, you only pay your cost-share.

INITIAL COVERAGE

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

Pharmacy Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		Standard Mail-Order Cost-Sharing		Preferred Mail-Order Cost-Sharing CenterWell Pharmacy™	
	30-day	100-day*	30-day	100-day*	30-day	100-day*
Day supply						
Tier 1: Preferred Generic	\$0	\$0	\$10	\$30	\$0	\$0
Tier 2: Generic	\$10	\$30	\$20	\$60	\$10	\$0
Tier 3: Preferred Brand	\$47	\$141	\$47	\$141	\$47	\$131
Tier 4: Non-Preferred Drug	48%	48%	48%	48%	48%	48%
Tier 5: Specialty Tier	25%	N/A	25%	N/A	25%	N/A

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

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

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

You won't pay more than **\$35** for a one-month (up to 30-day) supply of each plan-covered insulin product regardless of cost-sharing tier, even if you haven't paid your deductible.

Insulin Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		Standard Mail-Order Cost-Sharing		Preferred Mail-Order Cost-Sharing CenterWell Pharmacy™	
	30-day	100-day*	30-day	100-day*	30-day	100-day*
Day supply						
Tier 1: Preferred Generic	\$0	\$0	25% up to \$10	25% up to \$30	\$0	\$0
Tier 2: Generic	25% up to \$10	25% up to \$30	25% up to \$20	25% up to \$60	25% up to \$10	\$0
Tier 3: Preferred Brand	25% up to \$35	25% up to \$105	25% up to \$35	25% up to \$105	25% up to \$35	25% up to \$95
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

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

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

*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 **\$2,100** you pay **\$0** for plan-covered Part D and Excluded drugs.

EXCLUDED DRUG COVERAGE

Erectile dysfunction (ED) drugs Covered at Tier 1 cost-share amount.

Prescription vitamins Covered at Tier 1 cost-share amount.

EXTRA HELP

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

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

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

After reaching your annual **\$2,100** out-of-pocket limit, you will pay **\$0** for the remainder of the calendar year, regardless of the level of Extra Help you receive. Additional information will be available on your LIS rider.

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

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



Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
Acupuncture services (Medicare-covered)	\$45 copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.	\$45 copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Chiropractic services (Medicare-covered)	\$15 copay	50% of the cost
Podiatry services (Medicare-covered)	\$45 copay	50% of the cost
MEDICAL EQUIPMENT/SUPPLIES		
Continuous glucose monitor (CGM)		
• DME provider	\$0 copay	50% of the cost
• Pharmacy	\$0 copay	50% of the cost
Diabetic monitoring supplies		
• Diabetic supplier	20% of the cost	50% of the cost
• Network retail pharmacy	10% of the cost	50% of the cost
• Preferred diabetic supplier	\$0 copay	Not Covered
Durable medical equipment (DME)	20% of the cost	50% of the cost
Medical supplies at medical supplier	7% of the cost	50% of the cost
Prosthetics devices and related supplies at prosthetics provider	20% of the cost	50% of the cost
REHABILITATION SERVICES		
Cardiac rehabilitation services		
• Outpatient hospital	\$40 copay	50% of the cost
• Specialist's office	\$40 copay	50% of the cost
Occupational therapy		
• Comprehensive outpatient rehab facility	\$45 copay	45% of the cost
• Outpatient hospital	\$45 copay	45% of the cost
• Specialist's office	\$45 copay	45% of the cost



Additional Benefits (cont.)

Physical therapy

• Comprehensive outpatient rehab facility	\$45 copay	45% of the cost
• Outpatient hospital	\$45 copay	45% of the cost
• Specialist's office	\$45 copay	45% of the cost

Pulmonary rehabilitation

• Outpatient hospital	\$20 copay	50% of the cost
• Specialist's office	\$20 copay	50% of the cost

Speech therapy

• Comprehensive outpatient rehab facility	\$45 copay	45% of the cost
• Outpatient hospital	\$45 copay	45% of the cost
• Specialist's office	\$45 copay	45% of the cost

Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD)

• Outpatient hospital	\$10 copay	50% of the cost
• Specialist's office	\$10 copay	50% of the cost



More benefits with **this plan**

Enjoy some of these extra benefits included in this plan.

This is a summary of what we cover. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of coverage and services. Visit **Humana.com/PlanDocuments** to view a copy of the EOC or call **800-833-2364**.

Travel Coverage

The PPO national network gives you in-network coverage across the country, so you can see any doctor who accepts the plan terms and conditions. You'll be able to travel with ease or split your time between locations. Visit

Humana.com or contact Customer Care on the back of your ID card if you need help finding an in-network provider.

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.

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

Over-the-Counter (OTC) mail order

\$100 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.

- Quarterly allowance amounts are available to use at the beginning of January, April, July, and October.
- Limitations and restrictions may apply.

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

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

**Rewards and Incentives - Go365[®]
by Humana**

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

SilverSneakers[®] fitness program

Live a healthier, more active life through fitness and social connection at participating locations and online.

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

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



Find out **more**



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



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

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

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

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

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

Activate your secure MyHumana account.

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

Already have an account?

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

Don't have an account yet?

Create one using the same link above in just minutes.

Receiving information about other insurance products

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

Notice of Non-Discrimination

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

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

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

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

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

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

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Notice of Availability - Auxiliary Aids and Services Notice

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

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

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Չանգահարե՛ք՝ **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]: Lang gratis, èd oksilyè, ak lòt fòm sèvis disponib. Rele **877-320-1235 (TTY: 711)**.

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

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

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

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

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

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

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

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

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

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

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

GHHNOA2025HUM_0425

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 សេវាកម្មជំនួយផ្សេងៗសម្រាប់អ្នកប្រើប្រាស់។ ទូរសព្ទទៅលេខ **877-320-1235 (TTY: 711)**។

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

ພາສາລາວ [Lao]: ມີການບໍລິການດ້ານພາສາ, ອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ຮູບແບບທາງເລືອກອື່ນໃຫ້ໃຊ້ພໍ.

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

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

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

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

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

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

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

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

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు 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 các dịch vụ miễn phí về ngôn ngữ, hỗ trợ bổ sung và định dạng thay thế. Hãy gọi **877-320-1235 (TTY: 711)**.

አማርኛ [Amharic]: ቋንቋ፣ ኢንተር ማዳመጫ እና አማራጭ ቅርፅ ያላቸው አገልግሎቶችዎ ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

Bàsà [Bassa]: Wuḍu-xwínín-mú-zà-zà kùà, Hwòdǒ-fańa-nyo, kè nyo-boŭń-po-kà bě bé nyuεε se wídí pée-pée dǒ ko. **877-320-1235 (TTY: 711)** dá.

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

Òyìnbó [Yoruba]: Àwọn ìṣẹ̀ àtìlẹ̀hìn ìrànlọ́wọ̀ èdè, àtì ọ̀nà kíkà mírán wà lárọ̀wọ̀tọ̀. Pe **877-320-1235 (TTY: 711)**.

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

Humana.

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.

Notes

H7617014000

[illegible]

Notes

H7617014000

Humana Inc.

P.O. Box 14168
Lexington, KY 40512-4168

Important information about this plan

Humana.com



Get to know this plan's drug coverage with the Prescription Drug Guide

The Prescription Drug Guide—also called a formulary or drug list—is a robust list of prescription drugs that this plan covers. That way, you can confirm coverage for whatever prescription medicine you need.



Complete list of generic and brand-name drugs covered in this plan



Can be printed from, viewed on and downloaded to your smartphone, tablet and computer



Created and regularly updated by doctors and pharmacists



Available in multiple languages



View this plan's Prescription Drug Guide at **huma.na/20260015PDG** or scan the QR code with your smartphone or tablet's camera.



Questions? If you have questions, or to request a printed copy, call Customer Care at **800-457-4708 (TTY: 711)** daily, 8 a.m. to 8 p.m., from Oct. 1 – March 31; and Monday – Friday, 8 a.m. to 8 p.m., from Apr. 1 – Sept. 30.



Discover our network of 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 information on how to fill your 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: _____ / _____ / _____

FirstMiddleLastMonthDayYear

Address: _____

StreetCityStateZIP

Member ID: _____ Group # (if applicable): _____
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 maintains, including mental health, HIV, health status or substance use or disorder records. This also includes sharing information on mail-order pharmacy, wellness products, and health programs with the person being authorized.

☐ 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 and/or prescription coverage** ☐ **Vision** ☐ **Dental** ☐ **Centerwell Pharmacy™ (mail delivery)** ☐ **Go365®**

This information may be disclosed to, and used by, the following person or organization (such as nursing home, care provider, and care managers) to assist me with the Humana-owned products or services for which I am providing consent to disclose information:

Name: _____ Date of birth: _____ / _____ / _____

FirstMiddleLastRequired FieldMonthDayYear

Or if organization: _____

Name

Address: _____

StreetCityStateZIP

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 the following states—CA, CT, GA, IL, MA, MD, MT, NC, NJ, NV, OH, OR, VA—consents will expire in compliance with applicable state laws.[‡]
 - 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.
 - **THIS IS NOT A CONSENT for legally appointed POWER OF ATTORNEY.** By submitting this form, I am aware the person signing this consent is not permitted to request preauthorization's for medical or prescription coverage. Additionally, they cannot disenroll me, submit new enrollments, file a grievance, or request an appeal.



Member or Legal Representative signature _____ Date: ____ / ____ / ____ ☐

Member ☐ Legal Representative

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.

If you have a MyHumana account or plan to create one after enrolling, you can complete a consent form online from the “Accounts & Settings” page.

If you choose to 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 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: MT, VA

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

For Humana Use Only



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 48 hours prior to the scheduled appointment, except for Scope of Appointment forms that are completed during the last four days of a valid election period for the beneficiary or for unscheduled, in-person meetings (walk-ins) or inbound calls initiated by the beneficiary. 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 you may need a referral from a primary care physician to see a specialist.

Preferred provider organization (PPO) plan

In most cases, on this type of MA plan, you'll pay less if you use in-network providers. Referrals from a primary care doctor are not required.

Private fee-for-service (PFFS) plan

On this type of MA plan, you may go to any Medicare-approved doctor, hospital or provider that accepts the plan's payment, accepts the terms and conditions and agrees to treat you—but not all providers will.

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 nursing homes, 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 plans

Medicare Supplement plans are standardized plans that can be bought with varying coverage options to help supplement your Original Medicare plan. While an MA plan takes the place of Original Medicare, a Medicare Supplement plan is simply added on 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 cannot be paired or used with an MA 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.

Humana.

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 _____

Date and time of form completion:

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

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 scheduled appointment:

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

If the period between form completion and the scheduled appointment was less than 48 hours, indicate which exception was met to waive the 48-hour requirement:

[] Occurred during last four days of a valid election period for the beneficiary

[] Walk-in meeting initiated by beneficiary

[] Inbound call initiated by beneficiary

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.



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 **<https://huma.na/26appGNHHUTSEN>** 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 and hearing.

Humana offers individual dental and 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: A person should not send money to the issuer in response to the advertisement and 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



Humana Customer Care

For questions about claims, benefits or anything else regarding your Humana coverage, visit www.Humana.com/Help or call **800-457-4708 (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.

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.

IMPORTANT INFORMATION:

2026 Medicare Star Ratings

Official U.S.
Government
Medicare
Information



Humana - H7617

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

Overall Star Rating: ★★★★★

Health Services Rating: ★★★★★

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.

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at [Medicare.gov/plan-compare](https://www.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).

The number of stars show how well a plan performs.

★★★★★ EXCELLENT

★★★★☆ ABOVE AVERAGE

★★★☆☆ AVERAGE

★★☆☆☆ BELOW AVERAGE

★☆☆☆☆ POOR

Important resources guide

Keep this resource guide handy so you can easily and quickly get answers to your questions.

MyHumana

Create a secure online account.

MyHumana.com

Find Care

Need help finding a doctor or other care provider? Use our Find Care tool.

FindCare.Humana.com

Home healthcare services

If the plan you choose has home healthcare services, you can get access to healthcare from the comfort of home.

Humana.com/Home-Care

Virtual visits

If the plan you choose includes virtual visits, you can connect with a doctor via an internet-enabled device and receive care.

Humana.com/VirtualVisits

Supplemental Dental Benefits

If the plan you choose has embedded dental benefits, view the DENxxx benefit description to see what's covered.^{†††}

Humana.com/SB

Humana Community Navigator®

Get connected to resources in your community, like utility services, food assistance, housing support, transportation programs and more.

Humana.FindHelp.com

Go365 by Humana®

If the plan you choose includes Go365 by Humana®, you can earn rewards by completing healthy activities.

Go365.com

Dental, vision or hearing

Individual dental and vision plans, or combined dental, vision and hearing plans for added coverage.

Humana.com/Dental



Humana Customer Care

For questions about claims, benefits or anything else regarding 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. Please refer to the Summary of Benefits to learn if your plan includes Go365 by Humana. Go365 by Humana is offered on most plans at no extra charge.

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

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.