Humana 2026 MAPD

HMO

Humana Gold Plus Chronic Kidney Disease
H8908-006-000
Select Counties in MI
H8908006000MAPDEN26PODHMOF

MI:Genesee, Ingham, Lapeer, Livingston, Macomb, Oakland, Sanilac, St. Clair, Tuscola, Washtenaw, Wayne

# Enrollment book

## 2026 MAPD

**Medicare Advantage Prescription Drug Plan**

## The care you deserve

**so you can focus on your health**

Humana®

## 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


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


H8908-006-000

## 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.

HMO

# How this plan works

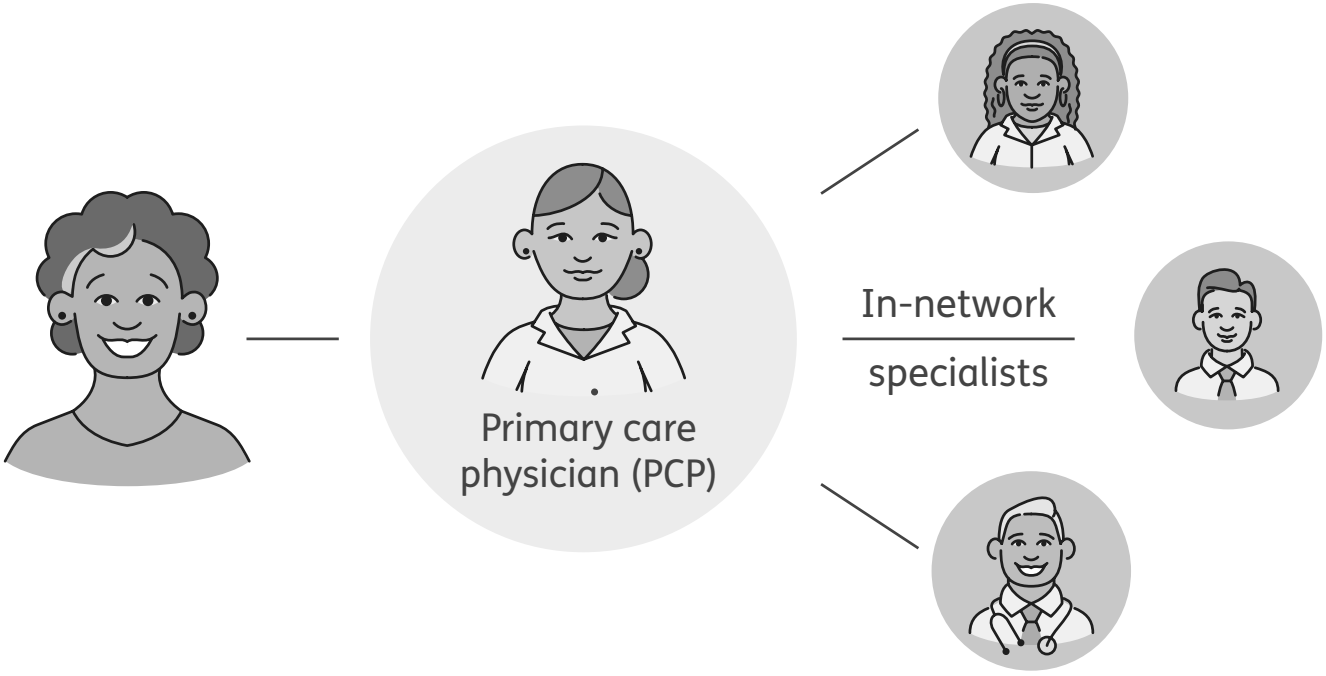
Here's how an HMO Medicare Advantage plan would work. (See all your Medicare options on the following page.)

### Health maintenance organization

Health maintenance organization (HMO) plans have their own network of doctors, hospitals and providers. You receive care in the HMO network. In general, your monthly premium (the payment you make each month) is lower than a preferred provider organization, or PPO, plan. You may also expect to pay less out of pocket, than with a PPO.

### Using an HMO plan

- You pick an in-network primary care physician (PCP) to manage your care.
- You may need a referral from your PCP to see a specialist.
- Out-of-pocket costs may not be covered for non-network providers and facilities, except for emergency care. In some cases, the costs are the same in and out of network.
- Select HMO plans include point-of-service benefits, which give you the option to choose out-of-network providers.
- 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.

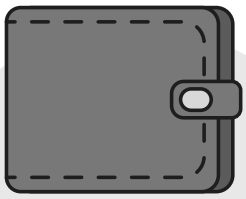
**Individual dental and vision plans or combined dental, vision and hearing plans** can help ensure coverage for all your healthcare needs.*

* 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.

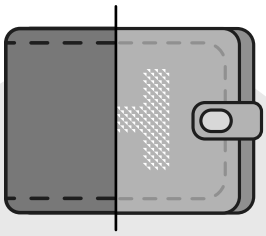
# Understanding the Part D Prescription Drug Stages



## STAGE 1

Deductible: **you pay 100%**

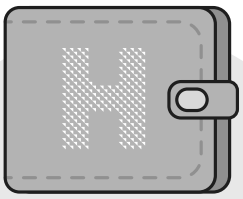
- A deductible is the amount you pay for your covered prescription drugs before the plan pays its share — you pay all costs until the deductible is met.
- Some plans may not have a deductible, allowing you to enter Stage 2 upon filling your first prescription of the year.
- Deductible amounts and tier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

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# Get health and wellness items you need

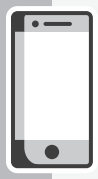
## with the **Humana over-the-counter mail-order allowance**

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.

CenterWell™ Pharmacy

* 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.

2026

# Summary of Benefits

## Humana Gold Plus Chronic Kidney Disease (HMO C-SNP) H8908-006

Detroit

Detroit Metro Area

Our service area includes the following county/counties in Michigan: Genesee, Ingham, Lapeer, Livingston, Macomb, Oakland, Sanilac, St. Clair, Tuscola, Washtenaw, Wayne.

## 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.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

# Let's talk about Humana Gold Plus Chronic Kidney Disease (HMO C-SNP)

Find out more about the Humana Gold Plus Chronic Kidney Disease (HMO C-SNP) plan – including the health and drug services it covers – in this easy-to-use booklet.

Humana Gold Plus Chronic Kidney Disease (HMO C-SNP) is a Special Needs plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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

## To be eligible

To join Humana Gold Plus Chronic Kidney Disease (HMO C-SNP), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be diagnosed with Chronic kidney disease (CKD) and live in our service area.

## Plan name

Humana Gold Plus Chronic Kidney Disease (HMO C-SNP)

## How to reach us

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

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

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

**Humana.com/Medicare**

## More about Humana Gold Plus Chronic Kidney Disease (HMO C-SNP)

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

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

As a member you must select an in-network doctor within the service area listed in this booklet to act as your Primary Care Provider (PCP). Humana Gold Plus Chronic Kidney Disease (HMO C-SNP) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services.

You also have access to Care Managers. Care Managers are nurses or care coordinators who are skilled at helping to improve your quality of life by providing proactive support and coordinating key services to help you better manage your health. If you're managing a serious illness or chronic condition, we'll be there to support you and your doctor's plan for care.

Humana.

## A healthy partnership

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

## Monthly Premium, Deductible and Limits

| | |
|---|---|
| **Monthly plan premium** | **$0**<br>You must keep paying your Medicare Part B premium. |
| **Medical deductible** | This plan does not have a deductible. |
| **Pharmacy (Part D) deductible** | **$0** deductible for Tier 1, Tier 2, Tier 3 and Tier 6<br>**$615** deductible for Tier 4 and Tier 5 |
| **Medical Maximum out-of-pocket responsibility** | **$9,100** in-network<br>The most you pay for copays, coinsurance and other costs for covered medical services for the year. |

## Medical Benefits

| | |
|---|---|
| **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 |
| **OUTPATIENT HOSPITAL COVERAGE** | |
| **Diagnostic colonoscopy** | **$0** copay |
| **Diagnostic mammography** | **$0** copay |
| **Surgery services** | **$435** copay |
| **AMBULATORY SURGERY CENTER** | |
| **Diagnostic colonoscopy** | **$0** copay |
| **Surgery services** | **$385** copay |
| **DOCTOR VISITS** | |
| **Primary Care Provider (PCP)** | • PCP's office: **$0** copay<br>• Telehealth: **$0** copay |
| **Specialist** | • Specialist's office: **$50** copay<br>• Telehealth: **$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****.*

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## Medical Benefits (cont.)

### PREVENTIVE CARE

This plan covers all Medicare preventive services including:

**Cancer Screenings**
- Breast cancer screening (mammogram)
- Cervical and vaginal cancer screening
- Colorectal cancer screening
- Lung cancer screening
- Prostate cancer screening

**Cardiovascular (heart) Care**
- Abdominal aortic aneurysm screening
- Cardiovascular disease risk reduction visit
- Cardiovascular disease screenings

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

**Dietary Guidance and Support**
- Medical nutrition therapy
- Obesity screening and therapy

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

**$0** copay

**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)

### 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.

**$115** copay

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## Medical Benefits (cont.)

| | |
|---|---|
| **URGENTLY NEEDED SERVICES** | |
| 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.** | • Telehealth: **$40** copay<br>• Urgent care center: **$40** copay |
| **DIAGNOSTIC SERVICES, LABS & IMAGING** | |
| **Advanced imaging services (MRI, MRA, PET and CT scans)** | • Freestanding radiological facility: **$200** copay<br>• Outpatient hospital: **$335** copay<br>• PCP's office: **$200** copay<br>• Specialist's office: **$280** copay |
| **Basic radiological services (X-rays)** | • Freestanding radiological facility: **$50** copay<br>• Outpatient hospital: **$130** copay<br>• PCP's office: **$0** copay<br>• Specialist's office: **$0** copay<br>• Urgent care center: **$40** copay |
| **Diagnostic mammography** | • Freestanding radiological facility: **$0** copay<br>• Specialist's office: **$0** copay |
| **Diagnostic procedures and tests** | • Outpatient hospital: **$105** copay<br>• PCP's office: **$0** copay<br>• Specialist's office: **$50** copay<br>• Urgent care center: **$40** copay |
| **Lab services** | • Freestanding laboratory: **$0** copay<br>• Outpatient hospital: **$35** copay<br>• PCP's office: **$0** copay<br>• Specialist's office: **$0** copay<br>• Urgent care center: **$40** copay |
| **Nuclear medicine and services** | • Freestanding radiological facility: **$200** copay<br>• Outpatient hospital: **$780** copay |
| **Sleep study** | • Member's home: **$0** copay<br>• Outpatient hospital: **$105** copay<br>• Specialist's office: **$105** copay |
| **Therapeutic radiology (Radiation therapy)** | • Freestanding radiological facility: **20%** of the cost<br>• Outpatient hospital: **20%** of the cost<br>• Specialist's office: **$0** copay |

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## Medical Benefits (cont.)

### HEARING SERVICES

| | |
|---|---|
| **Medicare-covered hearing** | **$30** copay |
| **Mandatory supplemental hearing benefit** | In-Network:<br>**HER957**<br>• **$0** copay for routine hearing exams up to 1 per year.<br>• **$399** copay for each Standard level hearing aid up to 1 per ear per year.<br>• **$699** copay for each Advanced level hearing aid up to 1 per ear per year.<br>• **$999** copay for each Premium level hearing aid up to 1 per ear per year.<br>Hearing aid purchase includes:<br>• Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase<br>• 60-day trial period<br>• 3-year extended warranty<br>• 80 batteries per aid for non-rechargeable models<br>• Rechargeable style options available for Premium and Advanced aids for an additional **$50** per aid<br>**You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (TTY: 711).** |

### DENTAL SERVICES

| | |
|---|---|
| **Medicare-covered dental** | **$50** copay |
| **Mandatory supplemental dental benefit**<br>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 | In-Network:<br>**DEN325**<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, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years.<br>• **$0** copay for bridge recementation, bridges-pontic, crown recementation, panoramic film or diagnostic x-rays up to 1 every 5 years.<br>• **$0** copay for bridges-crown up to 2 every 5 years.<br>• **$0** copay for crown, other restorative services - core buildup and prefabricated post and core, root |

*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.)

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).

Find a dentist in the nationwide Humana Dental Medicare network at **Humana.com/FindCare**.

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 emergency diagnostic exam 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.
- **$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.
- **$1,500** maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.

### VISION SERVICES

| | |
|---|---|
| **Eyewear (post cataract surgery)** | **$0** copay |
| **Medicare-covered diabetic eye exam** | **$0** copay |
| **Medicare-covered vision services**<br>The provider locator for Medicare-covered vision can be found at **Humana.com/FindCare**. | **$50** copay |
| **Mandatory supplemental vision benefit**<br>Please inform the network provider that you are part of the Humana Medicare Insight Network.<br>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.<br>The provider locator can be found at **Humana.com/FindCare**.<br>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. | In-Network:<br>**VIS734**<br>• **$0** copay for routine exam up to 1 per year.<br>• **$75** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.<br>• OR<br>• **$150** 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. |

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## Medical Benefits (cont.)

| | |
|---|---|
| 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.<br>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 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**. |
| **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 |
| **Mental health therapy visits** | • Outpatient hospital: **$35** copay<br>• Specialist's office: **$35** copay<br>• Telehealth: **$35** copay |
| **Outpatient substance abuse services** | • Outpatient hospital: **$35** copay<br>• Specialist's office: **$35** copay<br>• Telehealth: **$35** copay |
| **SKILLED NURSING FACILITY (SNF)** | |
| This plan covers up to 100 days in a SNF | **$0** copay per day for days 1-20<br>**$218** copay per day for days 21-100 |
| **AMBULANCE** | |
| | **$290** copay per date of service |
| **TRANSPORTATION** | |
| **Mandatory supplemental transportation benefit**<br>The member ***must*** contact transportation vendor at least 72 hours (3 business days) in advance of their appointment to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider. | **$0** copay for plan approved location up to unlimited one-way trip(s) per year.<br>This benefit is not to exceed 100 miles per trip. |
| **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<br>• Specialist's office: **$0** copay |
| **Chemotherapy drugs** | • Outpatient hospital: **20%** of the cost<br>• Specialist's office: **20%** of the cost |

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

## Medical Benefits (cont.)

| | |
|---|---|
| **Other Part B drugs** | • Outpatient hospital: **20%** of the cost<br>• PCP's office: **20%** of the cost<br>• Pharmacy: **20%** of the cost<br>• Specialist's office: **20%** of the cost |
| **Part B Insulin**<br>You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan. | • Outpatient hospital: **20%** of the cost<br>• PCP's office: **20%** of the cost<br>• Pharmacy: **20%** of the cost<br>• Specialist's office: **20%** of the cost |

## Prescription Drug Benefits

**PLAN HIGHLIGHTS**

| | |
|---|---|
| **$0 copays** | **$0** copays at select pharmacy locations and tiers. Additional details below. |
| **Deductible** | **$0** deductible for Tier 1, Tier 2, Tier 3 and Tier 6 |
| **Insulin costs** | You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan. |
| **100-day supply** | Up to 100-day supply on eligible drugs |
| **$0 vaccines** | **$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) |

**DEDUCTIBLE**

**$0** deductible for Tier 1, Tier 2, Tier 3 and Tier 6. This plan has a **$615** deductible for Tier 4 and Tier 5 drugs. You pay the full cost of these drugs until you reach **$615**. Then, you only pay your cost-share.

**INITIAL COVERAGE**

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

*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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| 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 | $10 | $30 | $0 | $0 |
| **Tier 2:** Generic | $0 | $0 | $20 | $60 | $0 | $0 |
| **Tier 3:** Preferred Brand | $47 | $141 | $47 | $141 | $47 | $131 |
| **Tier 4:** Non-Preferred Drug | 50% | 50% | 50% | 50% | 50% | 50% |
| **Tier 5:** Specialty Tier | 25% | N/A | 25% | N/A | 25% | N/A |
| **Tier 6:** Select Care Drugs | $0 | $0 | $11 | $33 | $0 | $0 |

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

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

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

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

| Insulin Cost-Sharing | | | | | | |
|---|---|---|---|---|---|---|
| | **Retail Cost-Sharing** Includes all in-network retail pharmacies | | **Standard Mail-Order Cost-Sharing** | | **Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy™ | |
| **Day supply** | **30-day** | **100-day*** | **30-day** | **100-day*** | **30-day** | **100-day*** |
| **Tier 1:** Preferred Generic | $0 | $0 | 25% up to $10 | 25% up to $30 | $0 | $0 |
| **Tier 2:** Generic | $0 | $0 | 25% up to $20 | 25% up to $60 | $0 | $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 |
| **Tier 6:** Select Care Drugs | $0 | $0 | 25% up to $11 | 25% up to $33 | $0 | $0 |

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

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

*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 drugs.

## 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.

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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

| | |
|---|---|
| **Acupuncture services (Medicare-covered)** | **$50** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year. |
| **Chiropractic services (Medicare-covered)** | **$15** copay |
| **Podiatry services (Medicare-covered)** | **$30** copay |
| **MEDICAL EQUIPMENT/SUPPLIES** | |
| **Continuous glucose monitor (CGM)** | • DME provider **$0** copay<br>• Pharmacy: **$0** copay |
| **Diabetic monitoring supplies** | • Diabetic supplier: **20%** of the cost<br>• Network retail pharmacy: **$0** copay<br>• Preferred diabetic supplier: **$0** copay |
| **Durable medical equipment (DME)** | • DME provider: **20%** of the cost |
| **Medical supplies** | • Medical supplier: **20%** of the cost |
| **Prosthetic devices and related supplies** | • Prosthetics provider: **20%** of the cost |
| **REHABILITATION SERVICES** | |
| **Cardiac rehabilitation services** | • Outpatient hospital: **$10** copay<br>• Specialist's office: **$10** copay |
| **Occupational therapy** | • Comprehensive outpatient rehab facility: **$5** copay<br>• Outpatient hospital: **$35** copay<br>• Specialist's office: **$10** copay |
| **Physical therapy** | • Comprehensive outpatient rehab facility: **$5** copay<br>• Outpatient hospital: **$35** copay<br>• Specialist's office: **$10** copay |
| **Pulmonary rehabilitation services** | • Outpatient hospital: **$10** copay<br>• Specialist's office: **$10** copay |
| **Speech therapy** | • Comprehensive outpatient rehab facility: **$5** copay<br>• Outpatient hospital: **$35** copay<br>• Specialist's office: **$10** copay |
| **Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)** | • Outpatient hospital: **$10** copay<br>• Specialist's office: **$10** copay |

# More benefits with **this plan**

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

**Over-the-Counter (OTC) Allowance**
**$60** quarterly allowance on a prepaid spending card to buy approved over-the-counter health and wellness products at participating retail locations or through the plan's approved OTC mail order vendor.

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.

**HMO Travel Benefit**
Members may receive in-network benefits when services are received from a participating HMO National Network provider when traveling to other states.

You must select an in-network doctor within the service area listed in this booklet to act as your Primary Care Provider (PCP).

**Routine foot care**
**$35** copay for routine podiatry visits up to unlimited visit(s) per year.

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**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.

**Rewards and Incentives - Go365® by Humana**
Complete eligible healthy activities, like preventive screenings and exams, and get rewarded with Go365 Advanced.

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

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

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

# 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.

Humana Gold Plus Chronic Kidney Disease (HMO C-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2026 based on a review of the Humana Gold Plus Chronic Kidney Disease (HMO C-SNP) Model of Care.

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

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



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# 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: Զանգահարե՛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 fòma sèvis disponib. Rele **877-320-1235 (TTY: 711)**.

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

فارسی [Farsi]: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **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]: નિઃશુલ્ક 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)**

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

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

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

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

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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 សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ ទូរសព្ទទៅ លេខ **877-320-1235 (TTY: 711)**។

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

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

Diné [Navajo]: Saad t'áá jiik'eh, t'áadoole'é binahjį' bee adahodooníłígíí diné bich'į' anídahazt'i'í, dóó łahgo át'éego bee hada'dilyaaígíí bee bika'aanída'awo'í dahólǫ. Kohjį' hodíilnih **877-320-1235 (TTY: 711)**.

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

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

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

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

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

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

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

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు 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፣ አጋዥ ማዳመጫ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችም ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

Bǎsɔ́ [Bassa]: Wuɖu-xwíníín-mú-zà-zà kǔà, Hwòɖǒ-fɔńɔ-ńnyɔ,́ kè nyɔ-bɔǔn-po-kà ɓě ɓé nyuɛɛ se wíɖí pɛ́ɛ̀-pɛ́ɛ̀ ɖò kɔ.̃ **877-320-1235 (TTY: 711)** ɖá.

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

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

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

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# Notes

# Notes

Humana.

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

Important information about this plan

Humana.com

H8908_SB_MAPD_HMO_006000_2026_M

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# 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/20260029PDG** 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.

CenterWell™ Pharmacy

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.

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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*

**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: _____ / _____ / _____
First Middle Last *Required Field* Month Day Year

Or if organization: _____
Name

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 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.

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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

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# 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.

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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.

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.

# 2026
# Enrollment Form

## Follow these easy steps to become a Humana Medicare member

### Have your Medicare card ready

Each individual applying must fill out a separate form.

### Sign and date the enrollment form

If the enrollment form is not completed and returned within the allotted time period, the enrollment could be denied.

### Submit your enrollment form

You may fax the Member Services pages of this enrollment form to: **1-877-889-9936**. Or mail this enrollment form to:

Humana Medicare Enrollment
P.O. Box 14309
Lexington, KY
40512-4309

Please don't send in the same enrollment form or apply to the same plan more than once.

### Call us with questions

If you have questions, please call a licensed Humana sales agent at **1-800-833-2367 (TTY: 711)**. We're available seven days a week, 8 a.m. – 8 p.m.

However, please note that our automated phone system may answer your call on holidays and during weekends April 1 – September 30. Please leave your name and telephone number, and we'll call you back by the end of the next business day.

### Electronic enrollment options

Have you considered enrolling online at **Humana.com/Medicare** instead? It's a fast, secure and easy way to apply.

## Instructions

- Completely fill the ovals.
- Use black ink only.
- Print only one clear number or capital block letter in each box.
- If you make a mistake, fix it by crossing out the box with an X. Put in the correct letter or number above or below the box as shown:

**Correct numbers and letters**


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# Additional Notes

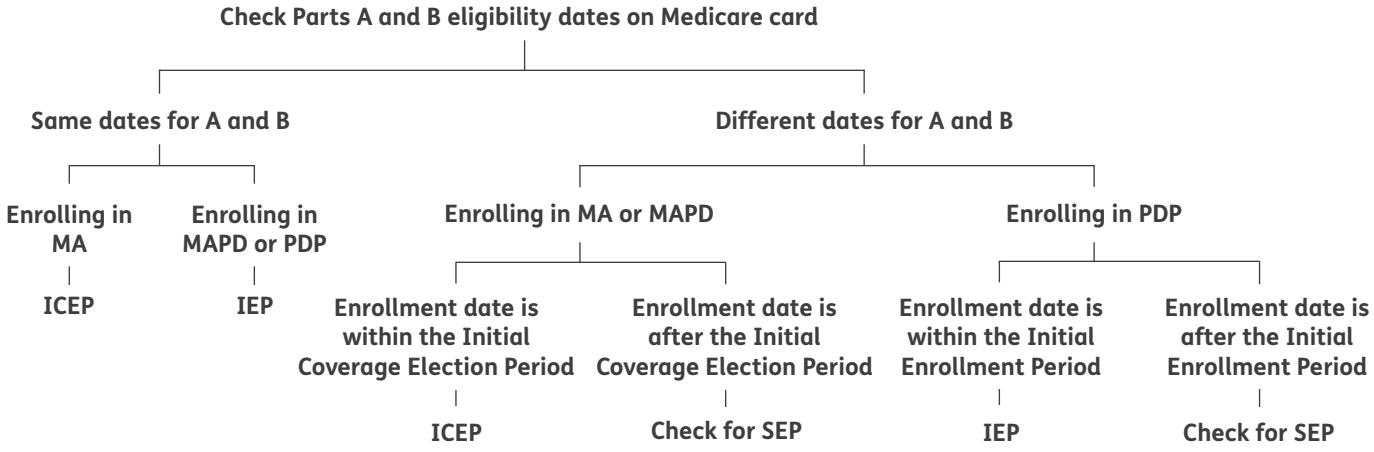
**Asterisks (*) indicate required fields**
Answering non-required fields is your choice. You can't be denied coverage if you don't complete them.

## Initial Enrollment Period (IEP) and Initial Coverage Election Period (ICEP)

- If Part A and Part B dates are the same, the election period spans 7 months: 3 months prior to the month you become eligible, the month you become eligible, and 3 months after the month you became eligible.
- If Part A and Part B dates are different, the election period spans 5 months: 3 months prior to the month of the later effective date (often Part B), the month you become eligible, and 1 month after the month you become eligible. Only for enrollment into a Medicare Advantage (MA)-only plan or a Medicare Advantage prescription drug (MAPD) plan. If enrollment is for a prescription drug plan (PDP), check to see if the 7-month IEP may still be available.
- The coverage start date is based on factors such as Medicare entitlement and the submission of the completed enrollment form.

When inputting your Medicare Number on the enrollment form, print it exactly as it is on your Medicare card. N indicates a number, A indicates an alphabetic character, and E indicates either a number or alphabetic character. Medicare numbers will not start with a zero or contain the letters B, I, L, O, S or Z.

Enrollment periods may overlap. Ensure you mark any Special Election Period (SEP) oval that applies to you from the list of SEP statements on page 4 of the enrollment form. When enrolling specifically during an SEP, one of the SEP statements must be true to be eligible for an SEP. Agents, please refer to the Enrollment Options Job Aid (DMS-024) found in Humana MarketPoint University in Vantage if you do not see the SEP listed on page 4.




## Scope Of Appointment (SOA) (Page 8)

Agents, please use one of the three-letter codes below for the appointment type field.

F2F – Face to Face
INH – In Home Appointment
OTH – Other
RET – Retail Partner
SEM – Seminar
TEL – Telephonic
WAL – Walmart

# 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)**.

**California members:**

You can also file a civil rights complaint with the California Dept. of Health Care Services, Office of Civil rights by calling **916-440-7370 (TTY: 711)**, emailing **Civilrights@dhcs.ca.gov**, or by mail at: Deputy Director, Office of Civil Rights, Department of Health Care Services, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413. Complaint forms available at: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**.

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

GHHNDN2025HUM

# Notice of Availability - Auxiliary Aids and Services Notice

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

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

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛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 fòma sèvis disponib. Rele **877-320-1235 (TTY: 711)**.

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

فارسی [Farsi]: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **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]: નિઃશુલ્ક 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)**

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

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

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

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

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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 សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ 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 ຮູບແບບທາງເລືອກອື່ນໃຫ້ໃຊ້ຟຣີ. ໂທ **877-320-1235 (TTY: 711)**.

Diné [Navajo]: Saad t’áá jiik’eh, t’áadoole’é binahjį’ bee adahodooníłígíí diné bich’į’ anídahazt’i’í, dóó łahgo át’éego bee hada’dilyaaígíí bee bika’aanída’awo’í dahólǫ. Kohjį’ hodíilnih **877-320-1235 (TTY: 711)**.

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

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

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

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

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

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

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

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు 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፣ አጋዥ ማዳመጫ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችም ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

Bǎsɔ́ ̀[Bassa]: Wuɖu-xwíníín-mú-zà-zà kǔà, Hwòɖǒ-fɔńɔ-ńnyɔ,́kè nyɔ-bɔǔn-po-kà bě bé nyuɛɛ se wíɖí pɛ́ɛ̀-pɛ́ɛ̀ ɖò kɔ.̀ **877-320-1235 (TTY: 711)** ɖá.

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

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

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

## PLEASE READ THIS IMPORTANT INFORMATION

**If you currently have health coverage from an employer or union, joining Humana could affect your employer or union healthcare benefits.** You could lose your employer or union health coverage if you join Humana.

**By completing this enrollment form, I agree to the following:**
If I am enrolling in a Medicare Advantage health plan that has a contract with the federal government, I will need to keep my Medicare Parts A and B to stay in the plan. I must continue to pay my Medicare Part B premium. If I am enrolling in a Medicare prescription drug plan, I will need to keep my Medicare Parts A or B coverage. It is my responsibility to inform Humana of any prescription drug coverage that I have or may get in the future. **I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.** With few exceptions, I can only be in one Medicare Advantage health plan or Medicare prescription drug plan at a time. I understand that my enrollment in my selected plan may end my enrollment in another Medicare Advantage health plan or prescription drug plan. Enrollment in my selected plan is generally for the entire year.

I understand that when my Humana coverage begins, I must get all of my medical and/or prescription drug benefits from Humana. Benefits and services provided by Humana and contained in my "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Humana will pay for benefits or services that are not covered. Benefits and services must be obtained from Humana in order to be covered as Medicare benefits, with the exception of hospice and kidney acquisition costs for transplants, which are covered by Medicare. I will abide by the rules of my Evidence of Coverage.

This Humana plan serves a specific service area. If I move out of the area that this Humana plan serves, I need to notify Humana so I can disenroll and find a new plan in my new area. Emergency coverage (both within and outside the plan's service area) and urgent care are always covered.

Sales agents/brokers may be compensated if they are helping the applicant enroll.

Once Humana has received my enrollment form, I may get a verification letter to make sure that I understand how my plan works and to confirm my intent to enroll. This is not a secondary plan to Medicare Parts A and B. Humana pays instead of Medicare, and I will be responsible for the amounts that Humana doesn't cover, such as copayments and coinsurances. Medicare Parts A and B won't pay for my healthcare while I am enrolled in a Medicare Advantage health plan with Humana.

- If you are requesting membership in a **Private Fee For Service (PFFS)** plan, the following statement applies: I understand that this plan is a Medicare Advantage PFFS plan which may have prescription drug coverage built in. Before seeing a provider, I should verify that the provider will accept this plan before each visit. My doctor or hospital isn't required to agree to accept the plan's terms and conditions, and thus may choose not to treat me, except for emergencies. I understand that my healthcare providers have the right to choose whether to accept a PFFS plan's payment terms and conditions every time I see them. I understand that if my provider decides not to accept PFFS, I will need to find another provider that will. I understand that if my PFFS plan doesn't offer Medicare prescription drug coverage, I may obtain coverage from another Medicare prescription drug plan.
- If you are requesting membership in a **Chronic Condition Special Needs Plan (C-SNP)**, the following statement applies: I understand this plan is a chronic condition special needs plan. My ability to enroll is based on physician verification that I have the qualifying medical condition(s).
- If you are requesting membership in an **Institutional Special Needs Plan (I-SNP)**, the following statement applies: I understand this plan is an institutional special needs plan. My ability to enroll is based on verification that my condition makes it likely that either the length of stay or the need for an institutional level of care would be at least 90 days; or, I reside in the community and meet state requirements for institutional level of care.

- I understand that I am enrolling into a Humana Medicare Advantage plan or a Humana Medicare prescription drug plan and not a Medicare Supplement, Medigap, Medicare Select or Medicaid plan.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

**Release of Information:**

By joining this Medicare plan, I acknowledge that Humana will share my information with the U.S. Department of Health and Human Services (HHS), who may use it to track my enrollment, to make payments, and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement below).

**Privacy Act Statement:**

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. **Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.**

**Individuals experiencing homelessness:**

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security benefit checks) may be considered and used in the residential address field as your permanent residence address.

# 2026 Humana Medicare Enrollment Form

Please print this information exactly as it is on your Medicare card.

**Print clearly. Use black ink.**
**Asterisks (*) indicate required fields.**

AGENT NUMBER (SAN)

DATE OF BIRTH* SEX*

M M – D D – Y Y Y Y ○ F ○ M

MEMBER ID NUMBER

H

(For current or past Humana members)

## MEDICARE HEALTH INSURANCE

LAST NAME*

FIRST NAME* MI

MEDICARE NUMBER*

N A E N – A E N – A A N N

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL (PART A) M M – 0 1 – Y Y Y Y

MEDICAL (PART B) M M – 0 1 – Y Y Y Y

Please see your agent to complete these questions.

PROPOSED COVERAGE START DATE*

M M – 0 1 – 2 0 2 6

(Must be after the sign date on page 8)

○ ICEP MA or MAPD ○ IEP PDP or MAPD ○ AEP ○ OEP ○ OEP NEW ○ OEPI ○ SEP CODE†

(See Additional Notes page)

†Required if SEP selected. See page 4 for code.

RESIDENTIAL ADDRESS* P.O. Box not allowed. ○ Experiencing homelessness

APT or STE

CITY* ST* ZIP*

COUNTY*

MAILING ADDRESS Your residential address confirms your service area. Print your mailing address/P.O. Box here, if applicable. If your mailing address is your residential address, please fill this oval. ○

APT or STE

CITY ST ZIP

It is important that we can reach you to help you stay informed and take care of your health. Please provide your telephone number and email address.

TELEPHONE

( ) –

TELEPHONE TYPE

○ Cellphone ○ Home (landline)

There may be times when Humana will use an automated system to call or text you. When that happens we will be sure to use the telephone number you provided.

EMAIL By providing your email address, you authorize Humana to send you health information to this address.

**Go paperless.** Many plan documents are now available in a digital format. See the enrollment book for a list of available communications and guidance on how to view your documents. To choose this option, please fill this oval. ○

We strongly recommend that all medical plan applicants include their primary care physician's (PCP) information below. If you are applying for an HMO plan, then you must complete this section. Please see your Summary of Benefits to determine if your plan requires a PCP.

PCP ID NUMBER

PRIMARY CARE PHYSICIAN (PCP)

**Are you already a patient of the physician you chose?** ○ Yes ○ No

**Asterisks (*) indicate required fields**

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

Typically, you may enroll in a Medicare Advantage or prescription drug plan during the Annual Election Period (AEP) between October 15 and December 7 of each year. In addition, you can choose to change your Medicare Advantage plan once during the annual Open Enrollment Period (OEP) between January 1 and March 31 of each year, or immediately after enrolling in a plan during your IEP/ICEP (OEP NEW). Limitations on allowed plan changes during OEP apply. There are exceptions that may allow you to enroll outside of these periods. Please read the following statements carefully and mark the oval to the left of any statement that applies to you. By marking any of the following ovals you are certifying that, to the best of your knowledge, the text is a true statement about you. **If we later determine that this information is incorrect, you may be disenrolled.**

| | SEP Code | **Special Election Period (SEP) statements** |
|---|---|---|
| ○ | **LEC** | I am either losing/leaving coverage I had from an employer or union or lost this type of coverage within the last two months. |
| ○ | **DEP** | I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I **HAVEN'T** had a change. **Note: This SEP is valid once per month throughout each year, and only for enrollment into a PDP.** |
| ○ | **NLS** | I had a change in my Extra Help paying for Medicare prescription drug coverage (newly got assistance, had a change in level or lost eligibility) within the last three months. |
| ○ | **MCD** | I had a change in my Medicaid status (newly got assistance, had a change in level or lost eligibility) within the last three months. |
| ○ | **MOV** | I am moving or have moved within the last two months. The move is either outside the service area for my current plan or this plan is a new option for me. |
| ○ | **SNP** | I have been notified that I no longer qualify for my Dual Eligible Special Needs Plan and am in a period of deemed continued eligibility or I was disenrolled from my Dual Eligible Special Needs Plan within the past three months due to a Medicaid change or loss. |
| ○ | **EOC** | My existing Medicare Advantage (MA) plan is ending its contract for the upcoming contract year. **Note: This SEP is only valid from December 8 through the last day of February.** |
| ○ | **OTH** | None of the above statements apply to me. However, I feel I have a special circumstance which allows me an exception to enroll. Humana will contact you to determine if an exception can be granted. **Must include the reason below.** |

Notes (if OTH):

**Asterisks (*) indicate required fields**

APPLICANT MEDICARE NUMBER*
N A E N – A E N – A A N N

## Plan selection

Please provide the plan information below for the medical or prescription drug plan you'd like.
Plan information can be found in your Summary of Benefits.

CONTRACT* PBP* SEGMENT
0 0

Please provide the base monthly premium for this plan from the Summary of Benefits. This amount helps us identify the plan you would like and should not include any OSB premium, late enrollment penalties or payments from other parties, like Medicaid.

BASE MONTHLY PREMIUM*
$ . 

Select one option below corresponding with the plan details you provided above.
Refer to your Summary of Benefits or your agent for assistance.

I would like **ONE** of the following options:*

- Humana Gold Plus® HMO
- Humana Gold Plus® Giveback HMO
- Humana USAA Honor Giveback HMO
- Humana Essentials Plus Giveback HMO
- Humana Gold Plus® HMO C-SNP (Additional Pre-Qualification Form Required)
- Humana Community HMO C-SNP (Additional Pre-Qualification Form Required)
- Humana Community HMO
- Humana Select Partner Plan HMO
- Humana Cleveland Clinic Preferred HMO
- Humana LCMC Advantage HMO
- Humana FMOL Network HMO
- Humana Total Complete HMO
- Humana Total Complete Giveback HMO
- HumanaChoice® PPO
- HumanaChoice® Giveback PPO
- Humana USAA Honor Giveback PPO
- Humana Essentials Plus Giveback PPO
- HumanaChoice® PPO C-SNP (Additional Pre-Qualification Form Required)
- Humana Together in Health PPO I-SNP (Additional Attestation Form Required)
- Humana Together in Health Select PPO I-SNP (Additional Attestation Form Required)
- Humana Senior Living Plan PPO I-SNP (Additional Attestation Form Required)
- Humana USAA Honor Giveback with Rx PPO
- Humana Full Access PPO
- Humana Full Access Giveback PPO
- Humana Value Plus PPO
- Humana Value Choice PPO
- Humana Direct Choice Giveback PPO
- Humana Basic Rx Plan (PDP)
- Humana Premier Rx Plan (PDP)
- Humana Value Rx Plan (PDP)
- Humana Gold Choice® PFFS

If selecting a Medicare Advantage HMO or PPO plan that does not include prescription drug coverage, a stand-alone prescription drug plan (PDP) cannot be carried at the same time.

**Asterisks (*) indicate required fields**

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

OPTIONAL SUPPLEMENTAL BENEFIT (OSB) YOU ARE ENROLLING IN:
OSB offerings are not available in all areas. **Please review your Summary of Benefits to see which Optional Supplemental Benefits are available for your plan.**

If you want to enroll in the OSB available for your plan, please fill in the oval.

◯ MyOption℠ DEN972

Applicants must continue to pay the Medicare Part B premium and the Humana plan premium plus the OSB premium.

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.

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**If you will have other prescription drug coverage (like VA, TRICARE) in addition to this plan for which you are applying, please fill this oval.*** ◯ I will have other prescription drug coverage

Please provide your other prescription drug coverage details here, if applicable.

NAME OF OTHER COVERAGE

ID NUMBER FOR THIS COVERAGE

GROUP NUMBER FOR THIS COVERAGE

---

**Once enrolled, will you or your spouse work?** ◯ Yes ◯ No

---

Preferred Written Language (when available)

◯ English ◯ Spanish ◯ Chinese ◯ Korean ◯ Other _____

Preferred Verbal Language

◯ English ◯ Spanish ◯ Mandarin ◯ Cantonese

◯ Korean ◯ Other _____

If an accessible format is needed, please select one option. If none are selected, you will receive standard font, printed materials.

◯ Audio ◯ Large print ◯ Accessible screen reader PDF

◯ Oral over the phone ◯ Braille ◯ Data CD

Please call **1-877-320-1235 (TTY:711)** if you need information in another format or language.

**Asterisks (*) indicate required fields**

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

**PLEASE SELECT ONE PREMIUM PAYMENT OPTION.** You may pay your monthly plan premium and/or late enrollment penalty via automatic deduction from your bank account, Social Security Administration (SSA) or Railroad Retirement Board (RRB) benefit check, or credit or debit card. You may also choose to pay by mail using a coupon book. **If you do not select a payment option below, you may be defaulted to a coupon book.**

**Automatic bank account deduction**
Bank account information (Only complete this section if you selected Automatic bank account deduction as your payment option).

Checking account Savings account

BANK NAME

ROUTING NUMBER ACCOUNT NUMBER


Routing number Account number

**Social Security benefit check deduction** (Please see note below)

**Railroad Retirement Board benefit check deduction** (Please see note below)
You must currently be receiving a Railroad Retirement Board benefit check in order to qualify for this payment option.

**NOTE:** Due to processing timelines mandated by CMS (Medicare), your SSA or RRB deduction may be denied for your first premium payment. Humana will issue you an invoice for the initial payment and resubmit your request to CMS (Medicare) for SSA or RRB deduction to begin with your second month's premium. The deduction may take two or more benefit checks to begin. In most cases, if SSA or RRB accepts your request for automatic deduction, the first deduction from your benefit check will start with the month that SSA accepts the withholding. If SSA or RRB does not approve your request for automatic deduction, we will send you a coupon book for your monthly premiums.

**Automatic credit or debit card deduction**
Credit or debit card information (Only complete this section if you selected Automatic credit or debit card deduction as your payment option).

Mastercard Visa Discover American Express

CREDIT OR DEBIT CARD NUMBER EXPIRATION DATE

M M – 2 0 Y Y

**Coupon book**

You can visit **Humana.com/pay** to make your monthly premium payments online. If you have selected coupon book as your payment option, you can pay as far in advance as you like. You can also log in to your secure MyHumana account (click Register if you haven't signed up yet) or download the MyHumana mobile app to take advantage of other premium-related services.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. Do NOT pay Humana the Part D-IRMAA.

**Asterisks (*) indicate required fields**

APPLICANT MEDICARE NUMBER*
N A E N – A E N – A A N N

I have read and understand the important information on the preceding pages. I have reviewed and received a copy of the Summary of Benefits.

SIGNATURE OF APPLICANT* or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc.)

SIGNATURE DATE*
M M – D D – 2 0 Y Y

I understand that my signature (or the signature of the individual legally authorized to act on my behalf) on this enrollment form means that I have read and understand the contents of this enrollment form. If signed by an authorized representative (as described above), the signature certifies that: 1) this individual is authorized under state law to complete this enrollment, and 2) documentation of this authority is available upon request by Medicare.

If you are the authorized legal representative, you **MUST** sign above and provide the following information:*

LAST NAME FIRST NAME MI

STREET ADDRESS

CITY ST ZIP

TELEPHONE
( ) –

RELATIONSHIP TO APPLICANT

**FOR INDIVIDUALS HELPING AN APPLICANT WITH COMPLETING THIS FORM ONLY**

Complete this section if you're an individual (e.g. agents, brokers, SHIP counselors, family members, or other third parties) helping an applicant fill out this form.

NAME SIGNATURE

RELATIONSHIP TO APPLICANT NATIONAL PRODUCER NUMBER (AGENTS/BROKERS ONLY)

**AGENT USE ONLY**

APPOINTMENT TYPE SCOPE OF APPOINTMENT ID NUMBER

WRITING AGENT NAME*

AGENT NUMBER (SAN)* DATE*
M M – D D – 2 0 Y Y

AFFINITY PARTNER LOCATION CAMPAIGN

REFERRING AGENT NAME

REFERRING AGENT NUMBER (SAN) CONTRACT* PBP* SEGMENT
0 0

ASK THE APPLICANT: Would you like to provide your Veteran status?*

Self Spouse Dependent I am not a Veteran Prefers not to answer

LEAD SOURCE*

Book of Business Event Marketing/Advertisement Third-Party Humana

Humana®

Humana.com

# Chronic Condition Special Needs Plan (SNP) Pre-Qualification Assessment

Last Name _____ First Name _____ MI _____

Medicare Number _____ Date of Birth _____

**CLINICAL QUALIFYING QUESTIONS FOR DIABETES**

If the applicant answers "Yes" to any of the following questions, then they pre-qualify for SNPs targeting applicants with diabetes.

1. Have you ever been told that you have high blood sugar or diabetes? ○ Yes ○ No
2. Have you ever or do you currently measure/monitor your blood sugar? ○ Yes ○ No
3. Have you been prescribed or do you take insulin or an oral medication that's supposed to lower your blood sugar? ○ Yes ○ No

**MEDICATION QUESTION** What medicines do you take for diabetes? _____

_____

**CLINICAL QUALIFYING QUESTIONS FOR CARDIOVASCULAR DISORDER**

If the applicant answers "Yes" to any of the following questions, then they pre-qualify for SNPs targeting applicants with cardiovascular disorders (CVD).

1. Do you have a problem with your heart, had a heart attack, or have you been told that you had a heart attack? ○ Yes ○ No
2. Do you have a problem with your circulation or have you been told that you have problems with your circulation? ○ Yes ○ No
3. Do you have pain in your legs when you walk that gets better when you stop and rest? ○ Yes ○ No

**MEDICATION QUESTION** What medicines do you take for CVD? _____

_____

**CLINICAL QUALIFYING QUESTIONS FOR CHRONIC HEART FAILURE**

If the applicant answers "Yes" to any of the following questions, then they pre-qualify for SNPs targeting applicants with chronic heart failure (CHF).

1. Have you ever been told you have heart failure or congestive heart failure? ○ Yes ○ No
2. Have you ever been told you have fluid in your lungs? ○ Yes ○ No
3. Have you ever been told you have swelling in your legs due to your heart? ○ Yes ○ No

**MEDICATION QUESTION** What medicines do you take for CHF? _____

_____

**CLINICAL QUALIFYING QUESTIONS FOR CHRONIC LUNG DISORDER**

If the applicant answers "Yes" to any of the following questions, then they pre-qualify for SNPs targeting applicants with chronic lung disorders (CLD).

1. Do you have any chronic breathing problems? ○ Yes ○ No
2. Have you ever been told you have a lung problem such as asthma, chronic bronchitis, chronic obstructive pulmonary disease (COPD), cystic fibrosis, emphysema, pulmonary fibrosis, and pulmonary hypertension, scarring in the lung, or high pressure in the lungs? ○ Yes ○ No
3. Do you use inhalers or other medicines for your breathing more than 3 times per week? ○ Yes ○ No

**MEDICATION QUESTION** What medicines do you take for CLD? _____

_____

# Chronic Condition Special Needs Plan (SNP) Pre-Qualification Assessment

Last Name _____ First Name _____ MI _____

Medicare Number _____ Date of Birth _____

**CLINICAL QUALIFYING QUESTIONS FOR DIABETES**

If the applicant answers "Yes" to any of the following questions, then they pre-qualify for SNPs targeting applicants with diabetes.

1. Have you ever been told that you have high blood sugar or diabetes? ○ Yes ○ No
2. Have you ever or do you currently measure/monitor your blood sugar? ○ Yes ○ No
3. Have you been prescribed or do you take insulin or an oral medication that's supposed to lower your blood sugar? ○ Yes ○ No

**MEDICATION QUESTION** What medicines do you take for diabetes? _____

_____

**CLINICAL QUALIFYING QUESTIONS FOR CARDIOVASCULAR DISORDER**

If the applicant answers "Yes" to any of the following questions, then they pre-qualify for SNPs targeting applicants with cardiovascular disorders (CVD).

1. Do you have a problem with your heart, had a heart attack, or have you been told that you had a heart attack? ○ Yes ○ No
2. Do you have a problem with your circulation or have you been told that you have problems with your circulation? ○ Yes ○ No
3. Do you have pain in your legs when you walk that gets better when you stop and rest? ○ Yes ○ No

**MEDICATION QUESTION** What medicines do you take for CVD? _____

_____

**CLINICAL QUALIFYING QUESTIONS FOR CHRONIC HEART FAILURE**

If the applicant answers "Yes" to any of the following questions, then they pre-qualify for SNPs targeting applicants with chronic heart failure (CHF).

1. Have you ever been told you have heart failure or congestive heart failure? ○ Yes ○ No
2. Have you ever been told you have fluid in your lungs? ○ Yes ○ No
3. Have you ever been told you have swelling in your legs due to your heart? ○ Yes ○ No

**MEDICATION QUESTION** What medicines do you take for CHF? _____

_____

**CLINICAL QUALIFYING QUESTIONS FOR CHRONIC LUNG DISORDER**

If the applicant answers "Yes" to any of the following questions, then they pre-qualify for SNPs targeting applicants with chronic lung disorders (CLD).

1. Do you have any chronic breathing problems? ○ Yes ○ No
2. Have you ever been told you have a lung problem such as asthma, chronic bronchitis, chronic obstructive pulmonary disease (COPD), cystic fibrosis, emphysema, pulmonary fibrosis, and pulmonary hypertension, scarring in the lung, or high pressure in the lungs? ○ Yes ○ No
3. Do you use inhalers or other medicines for your breathing more than 3 times per week? ○ Yes ○ No

**MEDICATION QUESTION** What medicines do you take for CLD? _____

_____

# Chronic Condition Special Needs Plan (SNP) Pre-Qualification Assessment

**CLINICAL QUALIFYING QUESTIONS FOR CHRONIC KIDNEY DISEASE**

If the applicant answers "Yes" to any of the following questions, then they pre-qualify for SNPs targeting applicants with chronic kidney disease (CKD).

1. Have you ever been told that you have end-stage renal disease (ESRD) or chronic kidney disease (CKD)? ○ Yes ○ No
2. Are you currently undergoing dialysis (hemodialysis or peritoneal dialysis)? ○ Yes ○ No
3. Are you currently awaiting a kidney transplant? ○ Yes ○ No

**MEDICATION QUESTION** What medicines do you take for ESRD or CKD? _____

_____

By filling this oval, I consent to Humana contacting my provider(s) to confirm my chronic condition(s). ○

Primary Care Physician/
Specialist Name _____ Telephone Number _____
Address _____ City _____ State _____ Zip _____

Applicant Signature _____ Date _____

This plan is available to individuals with certain chronic conditions. To qualify for a Chronic Condition Special Needs Plan, physician diagnosis of the condition must be verified. Applicants who do not have the condition will be disenrolled.

# Chronic Condition Special Needs Plan (SNP) Pre-Qualification Assessment

**CLINICAL QUALIFYING QUESTIONS FOR CHRONIC KIDNEY DISEASE**

If the applicant answers "Yes" to any of the following questions, then they pre-qualify for SNPs targeting applicants with chronic kidney disease (CKD).

1. Have you ever been told that you have end-stage renal disease (ESRD) or chronic kidney disease (CKD)? ○ Yes ○ No
2. Are you currently undergoing dialysis (hemodialysis or peritoneal dialysis)? ○ Yes ○ No
3. Are you currently awaiting a kidney transplant? ○ Yes ○ No

**MEDICATION QUESTION** What medicines do you take for ESRD or CKD? _____

_____

By filling this oval, I consent to Humana contacting my provider(s) to confirm my chronic condition(s). ○

Primary Care Physician/
Specialist Name _____ Telephone Number _____
Address _____ City _____ State _____ Zip _____

Applicant Signature _____ Date _____

This plan is available to individuals with certain chronic conditions. To qualify for a Chronic Condition Special Needs Plan, physician diagnosis of the condition must be verified. Applicants who do not have the condition will be disenrolled.

# 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)**.

**California members:**

You can also file a civil rights complaint with the California Dept. of Health Care Services, Office of Civil rights by calling **916-440-7370 (TTY: 711)**, emailing **Civilrights@dhcs.ca.gov**, or by mail at: Deputy Director, Office of Civil Rights, Department of Health Care Services, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413. Complaint forms available at: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**.

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

GHHNDN2025HUM

# Notice of Availability - Auxiliary Aids and Services Notice

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

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

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛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 fòma sèvis disponib. Rele **877-320-1235 (TTY: 711)**.

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

فارسی [Farsi]: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **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]: નિઃશુલ્ક 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)**

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

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

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

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

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 សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ ទូរសព្ទទៅ លេខ **877-320-1235 (TTY: 711)**។

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

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

Diné [Navajo]: Saad t’áá jiik’eh, t’áadoole’é binahjį’ bee adahodooníłígíí diné bich’į’ anídahazt’i’í, dóó łahgo át’éego bee hada’dilyaaígíí bee bika’aanída’awo’í dahólǫ. Kohjį’ hodíilnih **877-320-1235 (TTY: 711)**.

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

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

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

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

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

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

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

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు 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፣ አጋዥ ማዳመጫ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችም ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

Bǎsɔ́ ̀[Bassa]: Wuɖu-xwíníín-mú-zà-zà kǔà, Hwòɖǒ-fɔńɔ-ńnyɔ,́kè nyɔ-bɔǔn-po-kà bě bé nyuɛɛ se wíɖí pɛ́ɛ̀-pɛ́ɛ̀ ɖò kɔ.̀ **877-320-1235 (TTY: 711)** ɖá.

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

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

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

# Verification of Chronic Condition (VCC)

The member listed below has enrolled in a Humana Medicare Chronic Condition Special Needs Plan (C-SNP). To qualify for this Special Needs Plan, member diagnosis of the qualifying condition(s) must be verified by a physician or physician's office. **Please review the information below and send the completed verification to Humana right away. Members whose condition(s) cannot be verified are disenrolled from the plan.**

Member's Name: _____ Date of Birth: _____

Address: _____

Humana ID: _____ Medicare ID: _____

Proposed Effective Date: _____

**My signature below authorizes information about my chronic condition to be shared with Humana.** Note: While Humana does not require your signature, your physician may require this to release your personal information to us.

_____ _____

Member Signature Date

**To Be Completed by the Physician/Physician's Office**

Please check all the boxes that apply. By signing this form, you confirm the patient has been diagnosed with one or more of the following severe or disabling chronic conditions.

- ☐ None
- ☐ Diabetes
- ☐ Chronic Heart Failure
- ☐ Chronic Kidney Disease (CKD), requiring dialysis, CKD not requiring dialysis
- ☐ Chronic Lung Disease: Asthma, Cystic Fibrosis, Emphysema, Chronic Bronchitis, Pulmonary Fibrosis, Pulmonary Hypertension, Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Cardiovascular Disease: Cardiac Arrhythmias, Coronary Artery Disease, Peripheral Vascular Disease, Valvular Heart Disease

Confirmation provided by:

_____ _____

Physician/Office Staff Signature Date

_____ _____

Printed Name or Stamp Phone

Physicians/Office Staff can use the following ways to send the VCC to Humana:

- Via the **Availity** provider portal, or
- Fax this completed form to **1-877-889-9936**, or
- Scan this completed form and email to **VCC@humana.com**, or
- Call us at **1-877-271-5229** to provide verbal verification.
- (Monday – Friday, 8 a.m. to 6 p.m., Eastern time)

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# 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.

**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** | **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.

# IMPORTANT INFORMATION:

## 2026 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Humana - H8908

**For 2026, Humana - H8908 received the following Star Ratings from Medicare:**

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

**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).

# 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.