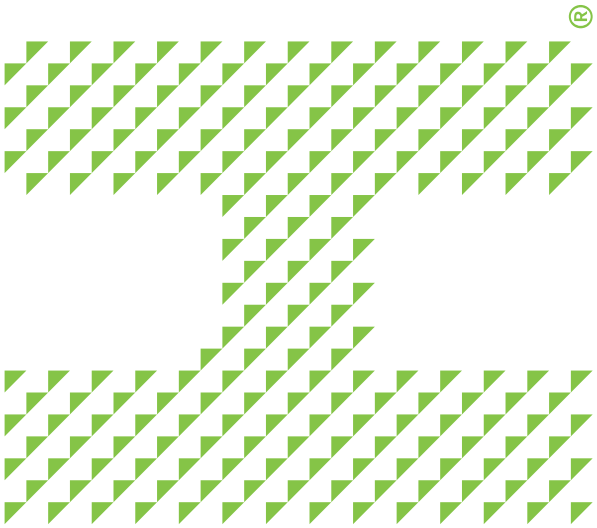
PFFS

Humana Gold Choice
H8145-084-000
Select Counties in TX
H8145084000MAPDEN24PODPFFSF

TX:Bandera, Bee, Bexar, Blanco, Bosque, Brazos, Burleson, Caldwell, Cameron, Camp, Cherokee, Coke, Coleman, Collin, Cooke, Dallas, Denton, El Paso, Falls, Fort Bend, Franklin, Freestone, Frio, Hardin, Harris, Hidalgo, Hill, Jefferson, Jim Wells, Kendall, Kleberg, Lamb, Lee, Llano, Lubbock, Lynn, Marion, Medina, Midland, Nueces, Polk, Potter, Randall, Refugio, San Jacinto, Swisher, Tarrant, Taylor, Trinity, Tyler, Van Zandt, Walker, Washington, Webb, Wharton, Willacy, Wilson, Wood, Zavala



Enrollment book

2024 MAPD

Better care begins with listening

so we can bring you more of what matters

Humana®

Listening to what you need, giving you support for your journey

When you tell us your health goals, we hear you—and we help you on your journey to reach them. Here's how:

- **Plan options** with copays and premiums designed to meet different needs
- A broad network of **doctors and pharmacies**
- **Dental, vision and hearing** coverage
- **Extra benefits** designed to help you along your health journey
- Resources at your fingertips with our simple **digital tools**
- Dedicated **customer service team** to help you make the most of your plan

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 helps 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.

Find programs, support and resources in your community at

Humana.FindHelp.com

What's inside

- **How your plan works**
- **Understanding your Medicare options**
- **Understanding the coverage gap**
- **The Humana difference**
- **Plan details**
  - Benefits at a glance
  - Summary of Benefits
- **Enrollment documents**
  - Privacy notice
  - Scope of appointment
  - Application
  - Application receipt
  - Star Rating document
- **Important resources guide**
- **What's next**

Your agent information

Agent name _____

Agent phone number _____

Agent email _____

Let's talk

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

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PFFS

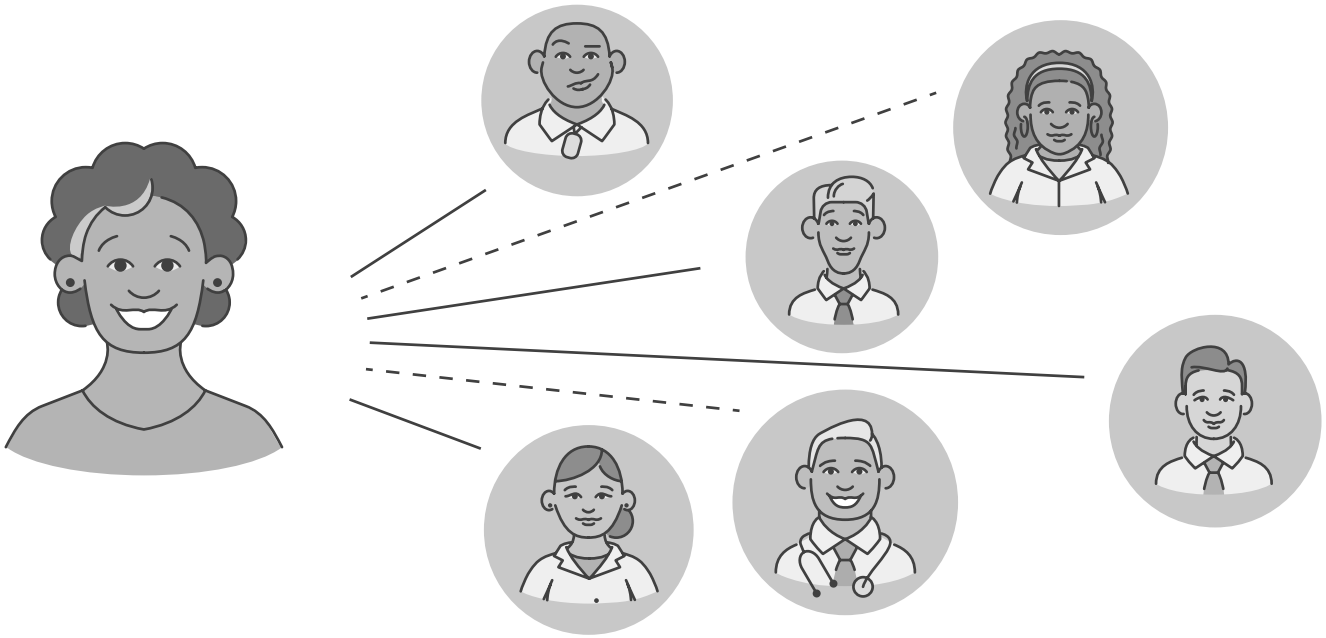
How your plan works

Private fee-for-service

Private fee-for-service (PFFS) plans give you the flexibility to see almost any Medicare-approved doctor, as long as the doctor accepts Humana's terms and conditions. PFFS plans determine the amount you pay for care from doctors, hospitals and other providers.

Using a PFFS plan

- This plan may offer more freedom to choose providers.
- You don't need a referral from your primary care physician (PCP) to see a specialist.
- Providers must be Medicare approved, accept Medicare and bill the plan per its terms and conditions.
- Be sure to always take your member ID card with you and clarify coverage before you receive services.



Understanding your Medicare options

To help you decide the best fit for you, here is an overview of Medicare options and what each one covers.
Follow these 2 steps to get started:

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 both of the following to Original Medicare.

Medicare Part C (Medicare Advantage) is made up of Part A, Part B and may include Part D (prescription drug benefits) as well as extra benefits like coverage for hearing, dental and vision.*

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.

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

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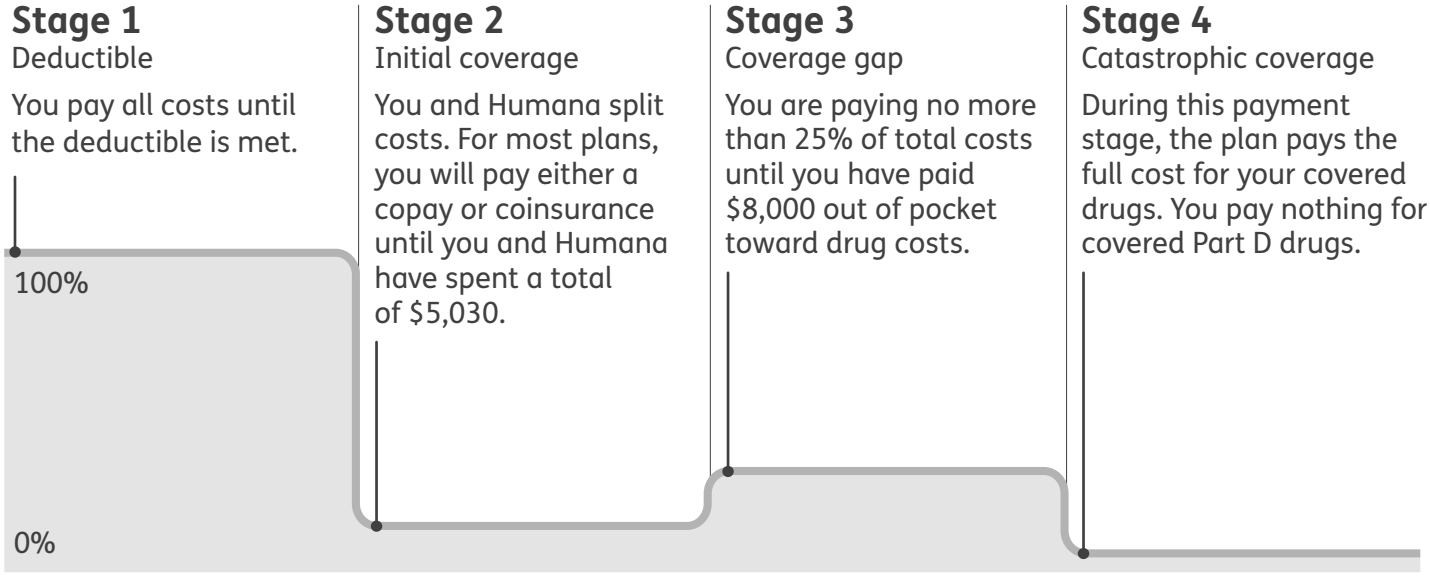
Understanding the coverage gap

Most Medicare prescription drug plans have a coverage gap. Once you enter the coverage gap, you may have to pay a higher percentage of drug costs for covered prescriptions. (Note that the information below only pertains to covered prescriptions and medication costs.)



Stage 1: Deductible—you pay 100%

- A deductible is the amount you pay of your medication costs before your plan pays its share.
- Some plans may have a deductible that does not apply to all tiers.
- You may have a reduced deductible or no deductible depending on the plan you choose in your area.

Stage 2: Initial coverage—shared cost with insurance company

- Both you and your insurance plan pay medication costs until the shared total drug costs equal $5,030.
- You're generally responsible for copays and coinsurance during this stage.

Stage 3: Coverage gap

- The coverage gap begins after you and your plan have spent $5,030 for covered drugs, and it ends when your out-of-pocket cost reaches $8,000.
- In this stage, you pay no more than 25% of the cost of brand-name and generic drugs.
- Any medication-related deductible, discounts you receive on covered brand-name drugs, coinsurance, copayments and the amounts you pay in the coverage gap count toward the $8,000 limit.

Stage 4: Catastrophic coverage stage—follows the coverage gap

- You enter the catastrophic coverage stage when your out-of-pocket costs have reached the $8,000 limit for the calendar year.
- During this payment stage, the plan pays the full cost for your covered drugs. You pay nothing for covered Part D drugs.

The Humana difference

Better care begins with listening. So that's just what Humana does. We listen to what you need and bring you support, with plan and benefit options to help you feel your best. There may be additional benefits beyond the ones listed here, depending on your plan and area. Going above and beyond for your whole health: That's human care.

Find a Doctor with Care Highlight

Need help finding a doctor? Use our Find a Doctor tool at **Humana.com/FindADoctor**. Many 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**.

Humana Neighborhood Center

Humana Neighborhood Center® offers free online and in-person events like healthy cooking demos, health education classes and social events. Meet one-on-one with a Humana Health Educator or get insights into your Medicare plan with a Customer Care specialist. Services are offered in the U.S. and Puerto Rico.

→ Visit **HumanaNeighborhoodCenter.com** to learn more.

Dental

Get dental coverage on every plan. Our dental coverage includes two free cleanings per year, a yearly exam and more.

Vision

Our vision coverage includes eye exams and a yearly allowance toward eyewear such as lenses or contacts.

Hearing

Our hearing benefits include routine exams and coverage for hearing aids.

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.

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The Humana difference

Pharmacy

You have several options for filling your prescriptions, including retail and mail-order pharmacies. CenterWell Pharmacy® is the preferred cost-sharing mail-order pharmacy on most Humana plans, offering free standard shipping. Other pharmacies are available in our network.

→ Learn more at **CenterWellPharmacy.com**. If you have questions, call CenterWell Pharmacy **at 855-310-5799 (TTY: 711)**, Monday – Friday, 8 a.m. – 11 p.m., and Saturday, 8 a.m. – 6:30 p.m., Eastern time.

Home healthcare

Get access to healthcare from the comfort of home. That includes primary and urgent care, as well as care for more serious conditions.

→ For more information, visit **Humana.com/Home-Care.**

Virtual visits

Have a checkup, sick visit or emotional health visit—without leaving home. Virtual care lets you connect with a doctor over an internet-enabled computer, tablet or phone. Check the Find a Doctor tool to see the doctors who offer virtual visits in your network. You may even be able to receive virtual care from your own doctor. (Not all doctors offer virtual visits.)

→ Visit **Humana.com/VirtualVisits** to learn more.

Go365 by Humana

If the plan you choose to enroll in includes Go365 by Humana®, each plan year you may earn rewards by completing healthy activities in Go365. These rewards can be redeemed for gift cards.† See all activities and rewards at **Go365.com/Medicare**.

Go365 is not included on the following plans: H5216-242, H5216-243, H5216-362, H5216-369, H5216-400, H5216-401, H5619-160, and H6622-088. Please refer to the Summary of Benefits to learn if your plan includes Go365 by Humana.

→ For more information, visit **Go365.com.**

Go365 by Humana is offered on most plans at no extra charge.

† No amount of this gift card can be used to purchase Medicare-covered services, nor can it be converted to cash. Rewards have no cash value and must be earned and redeemed within the same program year. Any rewards not redeemed by Dec. 31 will be forfeited.

2024 **Health Plan Benefits** at a Glance

Humana Gold Choice H8145-084 (PFFS) Select Counties in Texas

Plan Costs	With Medicare Only	With Medicare & State Cost-Share Protection
Monthly plan premium	$45	If you receive premium assistance, your plan premium may be reduced.
Annual out-of-pocket maximum	$6,700 combined in-network $6,700 combined in and out-of-network	$6,700 combined in-network $6,700 combined in and out-of-network If you are eligible for Medicare cost-sharing assistance under your state's Medicaid program, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

	In-Network With Medicare only	Out-of-Network With Medicare only	In-Network With Medicare & State Cost-Share Protection
Doctor Office Visits			
Primary care provider (PCP)	$10 copay	$20 copay	$0 copay
Specialist	$40 copay	$50 copay	$0 copay
Preventive Care			
Including: Medicare covered screenings	Covered at no cost when you see an in-network provider	Preventive screenings may have a cost share when you see an out-of-network provider.	$0 copay
Telehealth Services (in addition to Original Medicare)			
Primary care provider (PCP)	$0 copay	Not covered	$0 copay
Specialist	$40 copay	Not covered	$0 copay
Urgent care services	$55 copay	Not covered	$0 copay
Substance abuse or behavioral health services	$0 copay	Not covered	$0 copay

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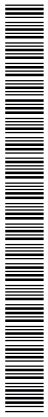
Inpatient Care			
Acute inpatient hospital care	$325 copay per day for days 1-5 $0 copay per day for days 6-90	$325 copay per day for days 1-5 $0 copay per day for days 6-90	$0 copay
Lab Services			
Lab tests from lab facility	$0 copay	30% of the cost	$0 copay
Lab tests from outpatient hospital facility	$50 copay	30% of the cost	$0 copay
Outpatient Care			
Outpatient surgery at ambulatory surgical center	$225 copay	30% of the cost	$0 copay
Physical therapy at therapy facility	$25 copay	30% of the cost	$0 copay
X-rays at outpatient hospital facility	$50 copay	30% of the cost	$0 copay
Diagnostic testing at outpatient hospital facility	$50 copay	30% of the cost	$0 copay
Mental Health Services			
Inpatient psychiatric hospital Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	$318 copay per day for days 1-5 $0 copay per day for days 6-90	$318 copay per day for days 1-5 $0 copay per day for days 6-90	$0 copay
Specialist's office	$30 copay	$50 copay	$0 copay
Outpatient hospital	$50 copay	30% of the cost	$0 copay
Partial hospitalization	$45 copay	30% of the cost	$0 copay
Emergency Services			
Urgently needed services at an urgent care center	$55 copay	$55 copay	$0 copay

Emergency Services (continued)			
Ground ambulance services	$265 copay per date of service	$265 copay per date of service	$0 copay
Emergency room	$90 copay	$90 copay	$0 copay
Additional Benefits & Programs			
Mandatory supplemental dental benefit DEN350	Included - cost share may apply. Please refer to the Summary of Benefits for additional details.		
Mandatory supplemental vision benefit VIS751	Included - cost share may apply. Please refer to the Summary of Benefits for additional details.		
Mandatory supplemental hearing benefit HER937	Included - cost share may apply. Please refer to the Summary of Benefits for additional details.		
Humana Well Dine® meal program	Included		



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2024 **Prescription Drug Benefits** at a Glance

Humana Gold Choice H8145-084 (PFFS) Select Counties in Texas

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

Deductible

$0 deductible for Tier 1, Tier 2 and Tier 3. This plan has a **$250** deductible for Tier 4, Tier 5 drugs. You pay the full cost of these drugs until you reach **$250**. Then, you only pay your cost-share.

Initial Coverage

You pay the following until your total yearly drug costs for covered drugs reach **$5,030**. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.

Pharmacy Cost-Sharing

Get more value with cost-share options in bold	**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	$6	$18	$10	$30	$6	**$0**
Tier 2: Generic	$12	$36	$20	$60	$12	**$0**
Tier 3: Preferred Brand	$47	$141	$47	$141	$47	**$131**

Day Supply	30-day	100-day*	30-day	100-day*	30-day	100-day*
Tier 4: Non-Preferred Drug	$99	$297	$100	$300	$99	**$287**
Tier 5: Specialty Tier	29%	N/A	29%	N/A	29%	N/A

Other pharmacies are available in our network. To find which pharmacies are available in your 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.

Once your total yearly drug costs—what is paid both by you and our plan—reach **$5,030**, the costs of your drugs may go up. Please refer to the Summary of Benefits for more information.

You can get more out of your plan by doing the following:

- **Stay in–network.** You may pay less for your drugs at in-network pharmacies.
- **Consider using your preferred mail order cost–sharing pharmacies.** They typically offer a lower cost-share than standard mail order cost-sharing pharmacies for most drugs (your cost-share for specialty drugs is the same at any in-network pharmacy).
- **Get a 100-day supply of many of the drugs you take all of the time.** You'll get more and may pay less, especially when you fill at a preferred cost-sharing mail order pharmacy.

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.

"Extra Help"

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

Prior to reaching your annual **$8,000** out-of-pocket limit you will pay one of the following depending on your level of "Extra Help:"

- **$4.50** for generic/preferred multi-source drug or biosimilar; **$11.20** for any other drug; OR
- **$1.55** for generic/preferred multi-source drug or biosimilar; **$4.60** for any other drug; OR
- **$0** for all drugs

After reaching your annual **$8,000** 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.

If you have questions and are a Humana member, please contact Customer Care at 1-800-457-4708 (TTY: 711).

If you are not currently a Humana member, please contact a licensed Humana sales agent at 1-844-775-9622 (TTY: 711), 8 a.m. to 8 p.m. seven days a week from Oct. 1, 2023 – Mar. 31, 2024 and Monday - Friday the rest of the year.

Humana is a Medicare Advantage PFFS plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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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 your plan may cover or other rules that may apply.

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

Get all your health plan details at
Humana.com/Benefits

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities.

- The following department has been designated to handle inquiries regarding Humana's non-discrimination policies: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235** (**TTY: 711)**.

Auxiliary aids and services, free of charge, are available to you. 877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

This information is available for free in other languages. Please call our customer service number at 877-320-1235 (TTY: 711). Hours of operation: 8 a.m. – 8 p.m. Eastern time.

Español (Spanish): Llame al número indicado para recibir servicios gratuitos de asistencia lingüística. **877-320-1235 (TTY: 711)**. Horas de operación: 8 a.m. a 8 p.m. hora del este.

繁體中文 (Chinese): 本資訊也有其他語言版本可供免費索取。請致電客戶服務部：**877-320-1235（聽障專線：711）**。辦公時間：東部時間上午 8 時至晚上 8 時。

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2024

Summary of Benefits

Optional Supplemental Benefits

Humana Gold Choice H8145-084 (PFFS)

Texas
Select Counties in Texas

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Our service area includes the following county/counties in Texas: Bandera, Bee, Bexar, Blanco, Bosque, Brazos, Burleson, Caldwell, Cameron, Camp, Cherokee, Coke, Coleman, Collin, Cooke, Dallas, Denton, El Paso, Falls, Fort Bend, Franklin, Freestone, Frio, Hardin, Harris, Hidalgo, Hill, Jefferson, Jim Wells, Kendall, Kleberg, Lamb, Lee, Llano, Lubbock, Lynn, Marion, Medina, Midland, Nueces, Polk, Potter, Randall, Refugio, San Jacinto, Swisher, Tarrant, Taylor, Trinity, Tyler, Van Zandt, Walker, Washington, Webb, Wharton, Willacy, Wilson, Wood, Zavala.

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 **1-800-833-2364 (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 **1-800-833-2364 (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 to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, 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 copayments/co-insurance may change on January 1, 2025.
- ☐ **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.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you may pay a higher co-pay for services received by non-contracted providers.

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Let's talk about Humana Gold Choice H8145-084 (PFFS)

Find out more about the Humana Gold Choice H8145-084 (PFFS) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Choice H8145-084 (PFFS) is a Medicare Advantage PFFS 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 Choice H8145-084 (PFFS), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

Humana Gold Choice H8145-084 (PFFS)

How to reach us:

If you're a member of this plan, call toll-free: **1-800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-833-2364 (TTY: 711)**.

October 1 - March 31:
Call 7 days a week from 8 a.m. - 8 p.m.

April 1 - September 30:
Call Monday - Friday, 8 a.m. - 8 p.m.

Or visit our website:

Humana.com/medicare

More about Humana Gold Choice H8145-084 (PFFS)

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

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

As a member it's a good idea to select a doctor as your Primary Care Provider (PCP). Humana Gold Choice H8145-084 (PFFS) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, you may be subject to higher copayments/coinsurance.

A healthy partnership

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

Monthly Premium, Deductible and Limits

PLAN COSTS	
Monthly plan premium	**$45** If you receive premium assistance, your plan premium may be reduced. You must keep paying your Medicare Part B premium.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	**$0** deductible on Tier 1, Tier 2 and Tier 3 **$250** for Tier 4, Tier 5
Maximum out-of-pocket responsibility	**$6,700** combined in- and out-of-network The most you pay for copays, coinsurance and other costs for covered medical services for the year.

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
INPATIENT HOSPITAL CARE		
Your plan covers an unlimited number of days for an inpatient stay.	**$325** copay per day for days 1-5 **$0** copay per day for days 6-90	**$325** copay per day for days 1-5 **$0** copay per day for days 6-90
OUTPATIENT HOSPITAL COVERAGE Services listed below may also be covered at other places of treatment. Please refer to specific services listed in this document for additional information.		
Advanced imaging services (MRI, MRA, PET and CT scan)	**$250** copay	**30%** of the cost
Basic radiological services (X-rays)	**$50** copay	**30%** of the cost
Cardiac rehabilitation services	**$20** copay	**30%** of the cost
Chemotherapy drugs	**20%** of the cost	**20%** of the cost
Diagnostic colonoscopy	**$325** copay	**30%** of the cost
Diagnostic mammography	**$50** copay	**30%** of the cost
Diagnostic procedures and tests - other	**$50** copay	**30%** of the cost
Lab services	**$50** copay	**30%** of the cost
Medicare Part B covered drugs	**20%** of the cost	**20%** of the cost
Mental health services	**$50** copay	**30%** of the cost
Nuclear medicine services	**$325** copay	**30%** of the cost

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Occupational therapy	**$25** copay	**30%** of the cost
Opioid treatment program services	**$50** copay	**30%** of the cost
Physical therapy	**$25** copay	**30%** of the cost
Pulmonary rehabilitation services	**$15** copay	**30%** of the cost
Renal dialysis services	**20%** of the cost	**20%** of the cost
Sleep study (facility based)	**$50** copay	**30%** of the cost
Speech therapy	**$25** copay	**30%** of the cost
Substance abuse care	**$50** copay	**30%** of the cost
Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD)	**$15** copay	**30%** of the cost
Surgery services	**$325** copay	**30%** of the cost
Therapeutic radiology (Radiation therapy)	**20%** of the cost	**30%** of the cost
Wound care	**$45** copay	**$50** copay
AMBULATORY SURGERY CENTER		
Diagnostic colonoscopy	**$225** copay	**30%** of the cost
Surgery services	**$225** copay	**30%** of the cost
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$10** copay	**$20** copay
Specialist's office	**$40** copay	**$50** copay
PREVENTIVE CARE		
	Our plan covers many preventive services at no cost when you see an in-network provider including: • Abdominal aortic aneurysm screening • Alcohol misuse screening & counseling • Annual Wellness Visit (AWV) • Bone mass measurement • Breast cancer screening (mammogram)	**$0** copay or **30%** of the cost, depending on the service and where service is provided Any additional preventive services approved by Medicare during the contract year will be covered.

	IN-NETWORK	OUT-OF-NETWORK
	• Cardiovascular disease risk reduction visit • Cardiovascular disease screenings • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screenings • Diabetes self-management training • Glaucoma screening • HIV screening • Immunizations • Lung Cancer Screening • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy • Prostate cancer screening • Routine physical exam • Sexually transmitted infections (STIs) screening and counseling • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • "Welcome to Medicare" preventive visit Any additional preventive services approved by Medicare during the contract year will be covered.	
EMERGENCY CARE		
Emergency services at emergency room	**$90** copay	**$90** copay
Physician and professional services at emergency room	**$0** copay	**$0** copay

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
URGENTLY NEEDED SERVICES		
Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical attention.	**$55** copay at an urgent care center	**$55** copay at an urgent care center
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Advanced imaging services (MRI, MRA, PET and CT scan)		
• Freestanding radiological facility	**$180** copay	**30%** of the cost
• Primary care physician's office	**$180** copay	**30%** of the cost
• Specialist's office	**$180** copay	**30%** of the cost
Basic radiological services (X-rays)		
• Freestanding radiological facility	**$50** copay	**30%** of the cost
• Primary care physician's office	**$10** copay	**$20** copay
• Specialist's office	**$40** copay	**$50** copay
• Urgent care center	**$55** copay	**30%** of the cost
Diagnostic colonoscopy at an ambulatory surgery center	**$225** copay	**30%** of the cost
Diagnostic mammography		
• Freestanding radiological facility	**$50** copay	**30%** of the cost
• Specialist's office	**$40** copay	**$50** copay
Diagnostic procedures and tests		
• Primary care physician's office	**$10** copay	**$20** copay
• Specialist's office	**$40** copay	**$50** copay
• Urgent care center	**$55** copay	**30%** of the cost
Lab services		
• Freestanding laboratory	**$0** copay	**30%** of the cost
• Primary care physician's office	**$0** copay	**$20** copay
• Specialist's office	**$0** copay	**$50** copay
• Urgent care center	**$55** copay	**30%** of the cost
Nuclear medicine and services at a freestanding radiological facility	**$225** copay	**30%** of the cost

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Sleep study		
• Member's home	**$0** copay	**30%** of the cost
• Specialist's office	**$50** copay	**30%** of the cost
Therapeutic Radiology (Radiation therapy)		
• Freestanding radiological facility	**20%** of the cost	**30%** of the cost
• Specialist's office	**$40** copay	**30%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**$40** copay	**$50** copay
Mandatory supplemental hearing benefit	**HER937** • **$0** copay for routine hearing exams up to 1 per year. • **$699** copay for each Advanced level hearing aid up to 1 per ear per year. • **$999** copay for each Premium level hearing aid up to 1 per ear per year. Hearing aid purchase includes: • Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models • Rechargeable style options available for an additional **$50** per aid. **You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (for TTY, dial 711).**	
DENTAL SERVICES The cost-share indicated below is what you pay for the covered service. Additional dental benefits are available with a separate monthly premium. Please see the "Optional Supplemental Benefits" page for details.		
Medicare-covered dental	**$40** copay	**$50** copay

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Mandatory supplemental dental benefit Limitations and exclusions may apply. 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 dental coverage limit. Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. Information regarding each plan is available at **Humana.com/sb**. In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule (annual maximum still applies). Out-of-network dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Members may be billed by the out-of-network provider for any	**DEN350** • **$0** copay for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **$0** copay for panoramic film or diagnostic x-rays up to 1 every 5 years. • **$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 fluoride treatment, 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 unlimited per year.	**DEN350** • **$0** copay for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **$0** copay for panoramic film or diagnostic x-rays up to 1 every 5 years. • **$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 fluoride treatment, 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 unlimited per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

	IN-NETWORK	OUT-OF-NETWORK
amount greater than the payment made by Humana to the provider. Please see below for provider locator instructions. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement. The coinsurance level will apply to the average negotiated in-network fee schedule (INFS) in your area. See Chapter 2 Payment Requests Contact Information in your Evidence of Coverage or visit **Humana.com** for information on requesting reimbursement. When visiting an out-of-network provider there could be a difference between Humana's reimbursement and the dentist's charges. Members are responsible for this difference when visiting an out-of-network provider; this is known as balanced billing. The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at **Humana.com** > Find a doctor > Select the Dentist icon from the menu > Enter Zip code > From the Distance drop down select the preferred distance > From the look up method select All Dental Networks > Then select HumanaDental Medicare.		

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
VISION SERVICES		
Eyewear (post cataract surgery)	**$0** copay	**30%** of the cost
Medicare-covered diabetic eye exam	**$0** copay	**$50** copay
Medicare-covered vision services The provider location for Medicare-covered vision can be found at **Humana.com** > Find a Doctor > select the Medical icon > enter Zip Code > select look up Method > Medicare or Medicare-Medicaid > select your plan Network > select Search Category > Specialty Physician	**$40** copay	**$50** copay

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Mandatory supplemental vision benefit The provider locator for the Humana Medicare Insight Network for Mandatory supplemental benefit vision can be found at **Humana.com** > Find a Doctor > select Vision care icon > Vision coverage through Medicare Advantage plans.	**VIS751** • **$0** copay for routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for routine exam. • **$100** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • **$150** maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year. • Maximum benefit coverage amounts cannot be combined. PLUS providers are part of the **Humana Medicare Insight Network** and are indicated in the provider locator search results.	**VIS751** • **$0** copay for routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for routine exam. • **$100** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. • Maximum benefit coverage amounts cannot be combined.
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$318** copay per day for days 1-5 **$0** copay per day for days 6-90	**$318** copay per day for days 1-5 **$0** copay per day for days 6-90
Therapy visits		
• Partial hospitalization	**$45** copay	**30%** of the cost
• Specialist's office	**$30** copay	**$50** copay

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
SKILLED NURSING FACILITY (SNF)		
Your plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$172** copay per day for days 21-100	**$0** copay per day for days 1-20 **$172** copay per day for days 21-100
PHYSICAL THERAPY		
Comprehensive outpatient rehab facility	**$25** copay	**30%** of the cost
Specialist's office	**$25** copay	**$50** copay
AMBULANCE		
Air	**20%** of the cost	**20%** of the cost
Ground	**$265** copay per date of service	**$265** copay per date of service
TRANSPORTATION		
	Not covered	
MEDICARE PART B DRUGS		
Allergy shots and serum		
• Primary care physician's office	**$15** copay	**$20** copay
• Specialist's office	**$25** copay	**$50** copay
Chemotherapy drugs at a specialist's office	**20%** of the cost	**20%** of the cost
Other Part B drugs Some rebatable Part B drugs may be subject to a lower coinsurance. You pay no more than $35 for a one-month (up to 30-day) supply for all Part B insulin covered by our plan, and if your plan has a deductible it does not apply to Part B insulin.		
• Pharmacy	**20%** of the cost	**20%** of the cost
• Primary care physician's office	**20%** of the cost	**20%** of the cost
• Specialist's office	**20%** of the cost	**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 on Tier 1, Tier 2 and Tier 3
Insulin costs	You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by your plan
100-day supply	Up to 100-day supply on eligible drugs
Additional gap coverage	Additional gap coverage for the following: Tier 1 drugs Tier 2 drugs Insulin
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

DEDUCTIBLE

$0 deductible for Tier 1, Tier 2 and Tier 3. This plan has a **$250** deductible for Tier 4, Tier 5 drugs. You pay the full cost of these drugs until you reach **$250**. Then, you only pay your cost-share.

INITIAL COVERAGE

You pay the following until your total yearly drug costs for covered drugs reach **$5,030**. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.

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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	$6	$18	$10	$30	$6	$0
Tier 2: Generic	$12	$36	$20	$60	$12	$0
Tier 3: Preferred Brand	$47	$141	$47	$141	$47	$131
Tier 4: Non-Preferred Drug	$99	$297	$100	$300	$99	$287
Tier 5: Specialty Tier	29%	N/A	29%	N/A	29%	N/A

Other pharmacies are available in your network. To find which pharmacies are available in your 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 3: Preferred Brand	$35	$105	$35	$105	$35	$105
Tier 5: Specialty Tier	$35	N/A	$35	N/A	$35	N/A

Other pharmacies are available in your network. To find which pharmacies are available in your 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.

COVERAGE GAP

After you enter the coverage gap, you pay **25 percent** of the plan's cost for covered brand name drugs and **25 percent** of the plan's cost for covered generic drugs until your out-of-pocket costs total **$8,000** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, **you may pay even less** for the following:

Tier 1 (Preferred Generic) - All Drugs

Tier 2 (Generic) - All Drugs

Tier 3 (Preferred Brand) - Insulin

Tier 5 (Specialty Tier) - Insulin

For more information on cost sharing in the coverage gap, please call us or access your Evidence of Coverage online.

CATASTROPHIC COVERAGE

After your yearly out-of-pocket drug costs reach **$8,000** 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 **$8,000** out-of-pocket limit you will pay one of the following depending on your level of "Extra Help:"

- **$4.50** for generic/preferred multi-source drug or biosimilar; **$11.20** for any other drug; OR
- **$1.55** for generic/preferred multi-source drug or biosimilar; **$4.60** for any other drug; OR
- **$0** for all drugs

After reaching your annual **$8,000** out-of-pocket limit, you will pay **$0** for the remainder of the calendar year, regardless of the level of "Extra Help" you receive. Additional information will be available on your LIS rider.

Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 Monday — Friday, 7 a.m. — 7 p.m. TTY users should call 1-800-325-0778. For more information on your prescription drug benefit, please call us or access your Evidence of Coverage online.

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

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
Chiropractic services (Medicare-covered)	**$15** copay	**$50** copay
Podiatry services (Medicare-covered)	**$40** copay	**$50** copay
Acupuncture services (Medicare-covered)	**$40** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.	**$50** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
MEDICAL EQUIPMENT/SUPPLIES		
Diabetic monitoring supplies		
• Diabetic supplier	**20%** of the cost	**20%** of the cost
• Network retail pharmacy	**10%** of the cost	**20%** of the cost
• Preferred diabetic supplier	**$0** copay	**Not Covered**
Durable medical equipment (DME) and related supplies	**20%** of the cost	**20%** of the cost
Medical supplies at medical supplier	**20%** of the cost	**20%** of the cost
Prosthetics devices and related supplies at prosthetics provider	**20%** of the cost	**20%** of the cost
REHABILITATION SERVICES		
Cardiac rehabilitation services at a specialist's office	**$15** copay	**$50** copay
Occupational therapy		
• Comprehensive outpatient rehab facility	**$25** copay	**30%** of the cost
• Specialist's office	**$25** copay	**$50** copay
Physical therapy		
• Comprehensive outpatient rehab facility	**$25** copay	**30%** of the cost
• Specialist's office	**$25** copay	**$50** copay
Pulmonary rehabilitation services at a specialist's office	**$15** copay	**$50** copay

Speech therapy • Comprehensive outpatient rehab facility	**$25** copay	**30%** of the cost
• Specialist's office	**$25** copay	**$50** copay
Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD) at a specialist's office	**$15** copay	**$30** copay
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care physician's office	**$0** copay	**Not Covered**
Specialist's office	**$40** copay	**Not Covered**
Substance abuse or behavioral health services	**$0** copay	**Not Covered**
Urgent care services	**$55** copay	**Not Covered**

More benefits with **your plan**

Enjoy some of these extra benefits included in your 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 **1-800-833-2364**.

Humana Well Dine® Meal Program
Humana's home delivered meal program for members following an inpatient stay in the hospital or nursing facility.

Rewards and Incentives
Go365 by Humana® a Rewards and Incentive program for completing certain preventive health screenings and health and wellness activities.

Optional **Supplemental Benefits**

Customize your coverage for an extra monthly premium when you enroll. You can choose from the following to help create your Medicare plan.

$25.40
Monthly premium

MyOption DEN204
MyOption DEN204 is an optional supplemental benefit package (OSB) that can be purchased for an additional monthly premium to replace any routine dental benefits that are offered within your Medicare Advantage plan. If purchased, the OSB will entirely replace the dental coverage defined in your benefits package. This means, you should disregard any language in the Mandatory Supplemental Dental Benefit section contained in Chapter 4 of the EOC. When you enroll, you will receive a new ID card showing your new DEN204 listed on the back. Any claim paid under the current year Mandatory Supplemental Benefit will apply toward the annual OSB maximum plan benefit.

$37.20
Monthly premium

MyOption DEN205
MyOption DEN205 is an optional supplemental benefit package (OSB) that can be purchased for an additional monthly premium to replace any routine dental benefits that are offered within your Medicare Advantage plan. If purchased, the OSB will entirely replace the dental coverage defined in your benefits package. This means, you should disregard any language in the Mandatory Supplemental Dental Benefit section contained in Chapter 4 of the EOC. When you enroll, you will receive a new ID card showing your new DEN205 listed on the back. Any claim paid under the current year Mandatory Supplemental Benefit will apply toward the annual OSB maximum plan benefit.

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2024

Optional Supplemental Benefits

Humana Gold Choice H8145-084 (PFFS)

Texas
Select Counties in Texas

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My Options, My Choice
Adding Benefits to Your Plan

You're unique and have unique needs. That's why Humana offers optional supplemental benefits (OSB). For an extra monthly premium, you can customize your Humana Medicare Advantage plan.

The information in this booklet will tell you about the benefits you can add to your plan. You can add these extra benefits when you sign up for your Medicare Advantage plan. You can also add these benefits after Medicare open enrollment ends on December 7 by contacting your agent or calling OSB sales at 1-888-413-7026. OSB sales is available from 8 a.m. – 8 p.m. local time, seven days a week October 1 – March 31, and Monday through Friday April 1 – September 30.

MyOption (DEN204)

The MyOption Dental benefit helps make it easy for you to plan for your dental care.

This benefit has no deductible.

Here's how the benefit works:

Monthly Premium	**$25.40**		
Maximum Benefit	Humana pays up to **$2,000** per calendar year		
Covered Dental Services	**In-Network* You Pay**	**Out-Of-Network** You Pay**	**Benefit Limitations**
Preventive Dental Services			
Periodic oral exam	**0%**	**0%**	Two per year
Emergency diagnostic exam	**0%**	**0%**	One per year
Bitewing X-rays	**0%**	**0%**	One per year
Intraoral X-rays (inside the mouth)	**0%**	**0%**	One per year
Full mouth or panoramic X-rays	**0%**	**0%**	One every five years
Prophylaxis (cleaning)	**0%**	**0%**	Two per year
Periodontal maintenance	**0%**	**0%**	Four per year
Fluoride	**0%**	**0%**	Two per year
Basic Dental Services (Minor Restorative)			
Amalgam restoration (silver filings)	**$25 Per tooth**	**$25 Per tooth**	Unlimited per year
Composite resin restoration (white filings)	**$25 Per tooth**	**$25 Per tooth**	

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations
Basic Dental Services (Minor Restorative)			
Extraction, erupted tooth or exposed root	**$25 Per tooth**	**$25 Per tooth**	Unlimited per year
Surgical removal of erupted tooth	**$25 Per tooth**	**$25 Per tooth**	
Recement crown	**$25**	**$25**	One every five years
Recement bridge	**$25**	**$25**	One every five years
Palliative (emergency) treatment of dental pain	**$25**	**$25**	Two per year
Anesthesia	**0%**	**0%**	Unlimited per year
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Periodontal scaling and root planing	**$25**	**$25**	One per quadrant every three years
Scaling – moderate or severe gingival inflammation	**$25**	**$25**	One every three years
Root Canal	**50%**	**50%**	One per tooth per lifetime
Root Canal retreatment	**50%**	**50%**	One per tooth per lifetime
Crowns	**50%**	**50%**	One per tooth per lifetime
Onlay	**50%**	**50%**	
Inlay – alternate benefit only	**50%**	**50%**	
Other restorative services - core buildup and prefabricated post and core	**50%**	**50%**	One per tooth per lifetime
Bridges - pontic	**50%**	**50%**	One every five years
Bridges - crown	**50%**	**50%**	Two every five years
Occlusal adjustment – limited	**50%**	**50%**	One every three years
Occlusal adjustment – complete	**50%**	**50%**	
Oral Surgery	**50%**	**50%**	Two per year

Limitations and exclusions may apply. 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 dental coverage limit.

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Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. Information regarding each plan is available at **Humana.com/sb**.

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

Out-of-network dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Members may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Please see below for provider locator instructions. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement. The coinsurance level will apply to the average negotiated in-network fee schedule INFS or usual and customary fees in your area. See Chapter 2 Payment Requests Contact Information in your Evidence of Coverage or visit **Humana.com** for information on requesting reimbursement.

When visiting an out-of-network provider there could be a difference between Humana's reimbursement and the dentist's charges. Members are responsible for this difference when visiting an out-of-network provider; this is known as balanced billing.

The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at **Humana.com > Find a doctor > Select the Dentist icon from the menu > From the Distance drop down select the preferred distance > Enter Zip code > From the look up method select All Dental Networks > Then select HumanaDental Medicare.**

MyOption (DEN205)

The MyOption Dental benefit helps make it easy for you to plan for your dental care.

This benefit has no deductible.

Here's how the benefit works:

Monthly Premium	**$37.20**		
Maximum Benefit	Humana pays up to **$2,000** per calendar year		
Covered Dental Services	**In-Network* You Pay**	**Out-Of-Network** You Pay**	**Benefit Limitations**
Preventive Dental Services			
Periodic oral exam	**0%**	**0%**	Two per year
Emergency diagnostic exam	**0%**	**0%**	One per year
Bitewing X-rays	**0%**	**0%**	One per year

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations
Preventive Dental Services			
Intraoral X-rays (inside the mouth)	**0%**	**0%**	One per year
Full mouth or panoramic X-rays	**0%**	**0%**	One every five years
Prophylaxis (cleaning)	**0%**	**0%**	Two per year
Periodontal maintenance	**0%**	**0%**	Four per year
Fluoride	**0%**	**0%**	Two per year
Basic Dental Services (Minor Restorative)			
Amalgam restoration (silver filings)	**0%**	**0%**	Unlimited per year
Composite resin restoration (white filings)	**0%**	**0%**	
Extraction, erupted tooth or exposed root	**0%**	**0%**	Unlimited per year
Surgical removal of erupted tooth	**0%**	**0%**	
Recement inlay, onlay or partial coverage restoration	**$25**	**$25**	One every five years
Recement indirectly fabricated or prefabricated post and core	**$25**	**$25**	
Recement crown	**$25**	**$25**	
Recement bridge	**$25**	**$25**	One every five years
Palliative (emergency) treatment of dental pain	**$25**	**$25**	Two per year
Anesthesia	**0%**	**0%**	Unlimited per year
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Periodontal scaling and root planing	**0%**	**0%**	One per quadrant every three years
Scaling – moderate or severe gingival inflammation	**0%**	**0%**	One every three years
Root canal	**50%**	**50%**	One per tooth per lifetime
Root canal retreatment	**50%**	**50%**	One per tooth per lifetime

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OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Crowns	**50%**	**50%**	One per tooth per lifetime
Onlay	**50%**	**50%**	
Inlay – alternate benefit only	**50%**	**50%**	
Other restorative services - core buildup and prefabricated post and core	**50%**	**50%**	One per tooth per lifetime
Bridges - pontic	**50%**	**50%**	One every five years
Bridges - crown	**50%**	**50%**	Two every five years
Complete denture (including routine post-delivery care) – maxillary (upper) or mandibular (lower)	**50%**	**50%**	One every five years
Immediate denture (including routine post-delivery care) – maxillary (upper) or mandibular (lower)	**50%**	**50%**	
Partial dentures (including routine post-delivery care) – resin or metal, maxillary (upper) or mandibular (lower)	**50%**	**50%**	One every five years
Unilateral partial denture (including routine post-delivery care)	**50%**	**50%**	
Complete denture adjustment – maxillary (upper) or mandibular (lower)	**50%**	**50%**	One per year
Partial denture adjustment – maxillary (upper) or mandibular (lower)	**50%**	**50%**	
Reline complete denture – maxillary (upper) or mandibular (lower)	**50%**	**50%**	One per year
Reline partial denture – maxillary (upper) or mandibular (lower)	**50%**	**50%**	

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Rebase complete denture – maxillary (upper) or mandibular (lower)	**50%**	**50%**	One per year
Rebase partial denture – maxillary (upper) or mandibular (lower)	**50%**	**50%**	
Repair complete denture base – maxillary (upper) or mandibular (lower)	**50%**	**50%**	One per year
Repair partial denture base – maxillary (upper) or mandibular (lower)	**50%**	**50%**	
Repair partial denture framework – maxillary (upper) or mandibular (lower)	**50%**	**50%**	
Replace missing or broken tooth	**50%**	**50%**	
Add tooth or clasp to partial denture	**50%**	**50%**	
Replace all teeth/acrylic – maxillary (upper) or mandibular (lower)	**50%**	**50%**	
Tissue conditioning – maxillary (upper) or mandibular (lower)	**50%**	**50%**	One per year
Occlusal adjustment – limited	**50%**	**50%**	One every three years
Occlusal adjustment – complete	**50%**	**50%**	
Oral surgery	**50%**	**50%**	Two per year

Limitations and exclusions may apply. 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 dental coverage limit. Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. Information regarding each plan is available at **Humana.com/sb**.

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OPTIONAL SUPPLEMENTAL BENEFITS (continued)

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 coinsurance payment still applies).

Out-of-network dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Members may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Please see below for provider locator instructions. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement. The coinsurance level will apply to the average negotiated in-network fee schedule INFS or usual and customary fees in your area. See Chapter 2 Payment Requests Contact Information in your Evidence of Coverage or visit **Humana.com** for information on requesting reimbursement.

When visiting an out-of-network provider there could be a difference between Humana's reimbursement and the dentist's charges. Members are responsible for this difference when visiting an out-of-network provider; this is known as balanced billing.

The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at **Humana.com > Find a doctor > Select the Dentist icon from the menu > From the Distance drop down select the preferred distance > Enter Zip code > From the look up method select All Dental Networks > Then select HumanaDental Medicare.**

Humana is a Medicare Advantage PFFS plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal. 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 throughout the year. Benefits may change on January 1st each year. Enrollees must use network providers for specific OSBs when stated in the Evidence of Coverage (EOC); otherwise, covered services may be received from non-network providers at a higher cost. Enrollees must continue to pay the Medicare Part B premium, their Humana premium, and the OSB premium.

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Notes

Notes

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Important

At Humana, it is important you are treated fairly.

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- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html.**
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

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Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

GHHLNNXEN 0623

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-320-1235 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-320-1235 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235（听障专线：711）。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-320-1235（聽障專線：711）。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다 . 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

Form CMS-10802 (Expires 12/31/25) Form Approved OMB# 0938-1421

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Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بخطتنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-320-1235 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-320-1235 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

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

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

Japanese：当社の健康保険と処方薬プランに関するご質問にお答えするために、無料の通訳サービスをご用意しています。通訳をご用命になるには、1-877-320-1235 (TTY：711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。

Form CMS-10802 (Expires 12/31/25) Form Approved OMB# 0938-1421

Find out **more**

You can see our plan's **provider and pharmacy directory** at our website at **humana.com/finder/search** or call us at the number listed at the beginning of this booklet and we will send you one.

You can see our 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.

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

Telehealth services shown are in addition to the Original Medicare covered telehealth. Your cost may be different for Original Medicare telehealth. Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services are for informational purposes only and should not be construed as medical advice. Please refer to your evidence of coverage for additional details on what your 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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The information you need is just a click away.

Visit Humana.com/PlanDocuments to check details about your plan, including benefits and costs.

If you'd like a printed Evidence of Coverage, Provider Directory, or Drug List mailed to you, you can request one online at the website above, or call **1-800-457-4708 (TTY: 711)**, 24 hours a day, seven days a week. Please have your Humana member ID card ready when you call. When asked for the reason you've called, say "Evidence of Coverage," "Drug List" or "Provider Directory."

Activate your secure MyHumana account.

Your online MyHumana account is an important part of your Humana membership. Use it to view your plan 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/MyHumanaPlan** and log in.

Don't have an account yet?

Create one using the same link above in just minutes.

Complete your Medicare Health Assessment

Reply to nine simple questions about your health. Your answers will help us guide you to tools and resources in your plan that may help you reach your health goals and live the way you want.

Two easy options

Call our automated voice service at **888-445-3379 (TTY: 711)**. Have your eight-digit member ID number handy—it's located on the front of your Humana member ID card.
OR log in to your MyHumana account.

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 those future calls by calling the Customer Care number on the back of your ID card.

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

Important information about your plan

Humana.com

H8145_SB_MAPD_PFFS_084000_2024_M

Humana®

Get to know your coverage with your Prescription Drug Guide

Your Humana Medicare Advantage plan includes prescription coverage—and plenty of support. One way we help you make the most of your plan is with your Prescription Drug Guide, also called a formulary or drug list. It's the robust list of prescription drugs or medicines that your plan covers. That way, you can confirm coverage for the medicine you need.

- **Complete list of generic and brand-name drugs covered in your plan**
- **Can be printed from, viewed on and downloaded to your phone, tablet and computer**
- **Created and regularly updated by doctors and pharmacists**
- **Available in multiple languages**

View your plan's Prescription Drug Guide at **Huma.na/49PDG495** or scan the QR code with your phone or tablet's camera.

Questions? Call **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 – Sep. 30

CenterWell™ Pharmacy

Discover our network of pharmacies—including simple and safe prescription delivery from **CenterWell Pharmacy®**—at **Humana.com/Pharmacy**. Check your plan's Evidence of Coverage for more information on how to fill your prescriptions.

Other pharmacies are available in the network.

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion, or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities.

- The following department has been designated to handle inquiries regarding Humana's non-discrimination policies: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711).**

Auxiliary aids and services, free of charge, are available to you. 877-320-1235 (TTY: 711)
Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

This information is available for free in other languages. Please call our customer service number at 877-320-1235 (TTY: 711). Hours of operation: 8 a.m. – 8 p.m. Eastern time.

Español (Spanish): Llame al número indicado para recibir servicios gratuitos de asistencia lingüística. **877-320-1235 (TTY: 711).** Horas de operación: 8 a.m. a 8 p.m. hora del este.

繁體中文 (Chinese): 本資訊也有其他語言版本可供免費索取。請致電客戶服務部：**877-320-1235 (聽障專線：711)**。辦公時間：東部時間上午 8 時至晚上 8 時。

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 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 or friend 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, you can complete a consent form online from the “Accounts & Settings” page.
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, PR, VA—consents will expire in compliance with applicable state laws.‡ I can cancel my consent at any time through my MyHumana account, by calling customer service, or by submitting a written notice to Humana.
- If I cancel consent, it will not apply to any information previously released with this authorization. Once information is shared, Humana cannot prevent the person or organization who has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.

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

❑ 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.

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

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* 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 & Puerto Rico

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

For Humana Use Only

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  If you need help filing a grievance, call **877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
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Language assistance services, free of charge, are available to you. 877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 **(Japanese)**: 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę́ nika'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

Scope of sales appointment form

It's important for you to understand the type of products 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 sales 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 in-bound 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 their legally authorized representative. We look forward to speaking with you.

The licensed sales agent who will discuss the products 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.

Stand-alone Medicare prescription drug plans (Part D)

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

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 coverage (MAPD) 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 get referrals from a primary care doctor.

Preferred provider organization (PPO) plan
In most cases, on this type of MA plan, you'll pay less if you use in-network doctors. 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 certain chronic medical conditions.

Other products

Medicare Supplement
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 held with an MA plan.

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

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

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

Humana.

Scope of sales 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

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 specifi types of products you initialed above. The person that 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
[ ] In-bound call initiated by beneficiary

Agent signature _____ Agent signature date _____/_____/_____

Plan(s) the agent represented _____

Application number—paper barcode, EHUB ID, Fast APP ID or recording ID _____

Date appointment completed _____/_____/_____

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

2024
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

Humana®

Additional Notes

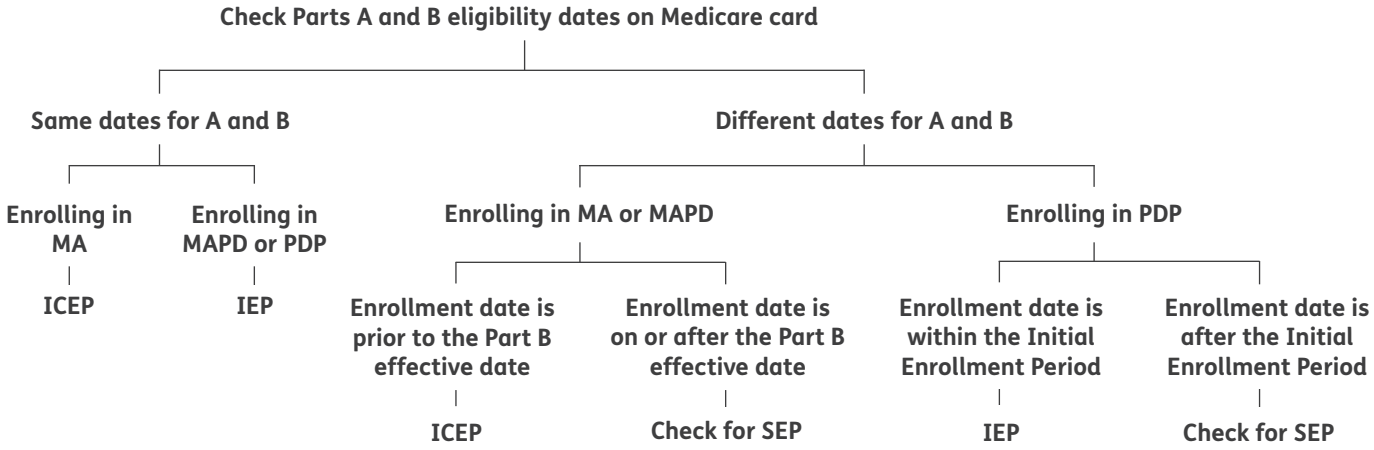
Asterisks (*) indicate required fields
Answering non-required fields is your choice. You can't be denied coverage if you don't complete them.

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 3 months: 3 months prior to the month of the later effective date (often Part B), 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, or contact the Agent Support Unit for assistance.



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
GCS – Neighborhood Center Seminar
GCW – Neighborhood Center Walk-in
INH – In Home Appointment
OTH – Other
RET – Retail Partner
SEM – Seminar
WAL – Walmart
TEL – Telephonic

Important

At Humana, it is important you are treated fairly.

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

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents:** You may also call the California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you.
1-877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

GHHLNNXEN 0623

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-320-1235 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-320-1235 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235（听障专线：711）。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-320-1235（聽障專線：711）。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다 . 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

Form CMS-10802 (Expires 12/31/25) Form Approved OMB# 0938-1421

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بخطتنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-320-1235 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-320-1235 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

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

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

Japanese：当社の健康保険と処方薬プランに関するご質問にお答えするために、無料の通訳サービスをご用意しています。通訳をご用命になるには、1-877-320-1235 (TTY：711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。

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 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. I will abide by the rules of my Evidence of Coverage. Once I am a member of Humana, I have the right to appeal plan decisions about payment or services if I disagree.

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. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.

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 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.

- 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 Medicare, 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.

2024 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 ○ M ○ F

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 4

(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.
○	**MDE**	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 only valid once per calendar quarter from January 1 through September 30.**
○	**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.
○	**DST**	I was affected by a Federal Emergency Management Agency (FEMA) declared emergency/ disaster or a disaster or other emergency declaration issued by a federal, state or local government entity, and was unable to use another election period available to me due to it. Election Period Missed: _____ Emergency/Disaster Experienced: _____
○	**EOC**	My existing Medicare Advantage (MA) plan is ending its contract for the upcoming contract year. **Note: (formerly NON) 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 options, 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 Value Plus HMO
- Humana USAA Honor HMO
- Humana Gold Plus® HMO C-SNP (Additional Pre-Qualification Form Required)
- Humana Community HMO C-SNP (Additional Pre-Qualification Form Required)
- Humana Together in Health HMO I-SNP (Additional Attestation Form Required)
- Humana Community HMO
- Humana Community Select HMO
- Humana Select Partner Plan HMO
- Humana Cleveland Clinic Preferred HMO
- Humana LCMC Advantage HMO
- UC San Diego Health Humana HMO
- Humana FMOL Network HMO
- Humana BR Clinic-BR Gen HMO
- HumanaChoice® PPO
- Humana Value Plus PPO
- Humana USAA Honor PPO
- HumanaChoice® PPO C-SNP (Additional Pre-Qualification Form Required)
- Humana Together in Health PPO I-SNP (Additional Attestation Form Required)
- HumanaChoice® Value PPO
- HumanaChoice® Partnered PPO
- Humana USAA Honor with Rx PPO
- Humana Care Extra PPO
- Humana Basic Rx Plan (PDP)
- Humana Premier Rx Plan (PDP)
- Humana Walmart 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:

Please fill in the ovals for the OSBs you want to enroll in. If you're currently enrolled in an OSB, you **MUST** choose it on this form to continue receiving this benefit. Not all OSB offerings are available in all areas. **Please review the OSB options below and your Summary of Benefits to verify that yours are still offered and available.**

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

- MyOption℠ Platinum Dental
- MyOption℠ Dental – High
- MyOption℠ Plus
- MyOption℠ Vision
- MyOption℠ DEN204
- MyOption℠ DEN205
- MyOption℠ DEN206
- MyOption℠ DEN207
- MyOption℠ DEN432
- MyOption℠ DEN478

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1. 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

---

2. 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

Audio Large print Accessible screen reader PDF

Oral over the phone Braille

Please call a licensed Humana sales agent at **1-800-833-2367 (TTY: 711)** if you need information in another format or language.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- No, not of Hispanic, Latino/a, or Spanish origin
- Yes, Puerto Rican
- Yes, another Hispanic, Latino/a, or Spanish origin
- Yes, Mexican, Mexican American, Chicano/a
- Yes, Cuban
- I choose not to answer

What's your race? Select all that apply.

- American Indian or Alaska Native
- Chinese
- Japanese
- Other Asian
- Vietnamese
- Asian Indian
- Filipino
- Korean
- Other Pacific Islander
- White
- Black or African American
- Guamanian or Chamorro
- Native Hawaiian
- Samoan
- I choose not to answer

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 (ACH), Social Security Administration (SSA) or Railroad Retirement Board (RRB) benefit check, or credit or debit card (CC/DC). 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. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. 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

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)

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 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 throughout the year. Benefits may change on January 1 each year.

Humana®

Humana.com

Y0040_SP_APP_FL_2024_C 07122023

GNHHUTSEN_2024

Care that's all about you

This signifies the receipt of enrollment in a Humana Medicare plan. Note: Enrollment is pending review and final approval by Medicare 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 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

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:

- ❑ MyOption℠ Dental – High (DEN838)
- ❑ MyOption Platinum Dental (DEN887)
- ❑ MyOption Plus (VIS759/DEN843)
- ❑ MyOption Vision (VIS757)
- ❑ MyOption DEN204
- ❑ MyOption DEN205
- ❑ MyOption DEN206
- ❑ MyOption DEN207
- ❑ MyOption DEN432
- ❑ MyOption DEN478

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) plan or prescription drug plans (PDP) (Part D)	PCN: 03200000
	BIN: 015581
Medicare Advantage 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 **Humana.com/Help** or call **800-457-4708 (TTY: 711)**.

Oct. 15 – Dec. 7	**Dec. 8 – Oct. 14**
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 **866-291-9714** 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 throughout the year. Benefits may change on Jan. 1 each year. Enrollees must continue to pay the Medicare Part B premium, their Humana plan premium and the OSB premium.

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion, or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities.

- The following department has been designated to handle inquiries regarding Humana's non-discrimination policies: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**.

Auxiliary aids and services, free of charge, are available to you.
877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

This information is available for free in other languages. Please call our customer service number at 877-320-1235 (TTY: 711). Hours of operation: 8 a.m. – 8 p.m. Eastern time.

Español (Spanish): Llame al número indicado para recibir servicios gratuitos de asistencia lingüística. **877-320-1235 (TTY: 711).** Horas de operación: 8 a.m. a 8 p.m. hora del este.
繁體中文 (Chinese): 本資訊也有其他語言版本可供免費索取。請致電客戶服務部：**877-320-1235（聽障專線：711）**。辦公時間：東部時間上午 8 時至晚上 8 時。

IMPORTANT INFORMATION:

2023 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Humana - H8145

For 2023, Humana - H8145 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★★☆
Health Services Rating:	★★★★½
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 800-833-2364 (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).

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Important resources guide

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

Find a Doctor
Humana.com/FindADoctor

Go365 by Humana
Go365.com

Home healthcare
Humana.com/AtHome

Virtual visits
Humana.com/VirtualVisits

Pharmacy education
844-330-0816

Create a MyHumana account
MyHumana.com

Humana Neighborhood Center
HumanaNeighborhoodCenter.com

Search and connect to support in your ZIP code
Humana.FindHelp.com

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. 15 – Dec. 7
Daily
8 a.m. – 8 p.m.

Dec. 8 – Oct. 14
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 Humana sales agent to find out what benefits are included in your plan.

Humana.

What's next

Once you complete your enrollment application and it is approved by the Centers for Medicare & Medicaid Services, 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 summary of benefits and costs.

Get this information sent right to your MyHumana account:

- Summary of Benefits and value-added items and services that may be available with your 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 MyHumana account and confirm your communication preferences.

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

Other pharmacies are available in the network.

Humana is a Medicare Advantage HMO, PPO and PFFS organization with a Medicare contract. Humana is also a Coordinated Care plan with a Medicare contract and a contract with the state Medicaid program. Enrollment in any Humana plan depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat Plan/Part D sponsor 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.

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繁體中文 (Chinese): 本資訊也有其他語言版本可供免費索取。請致電客戶服務部：**877-320-1235（聽障專線：711）**。辦公時間：東部時間上午 8 時至晚上 8 時。