Humana 2024 DSNP

PPO

HumanaChoice SNP-DE
H5970-020-000
Select Counties in NY
H5970020000DSNPEN24PODPPOF

NY:Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Columbia, Cortland, Delaware, Dutchess, Erie, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Ulster, Warren, Washington, Westchester, Wyoming, Yates

Enrollment book

2024 DSNP

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
- An allowance to help you pay for eligible **groceries, rent, utilities** and more
- 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**
- **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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PPO

How your plan works

Preferred provider organization

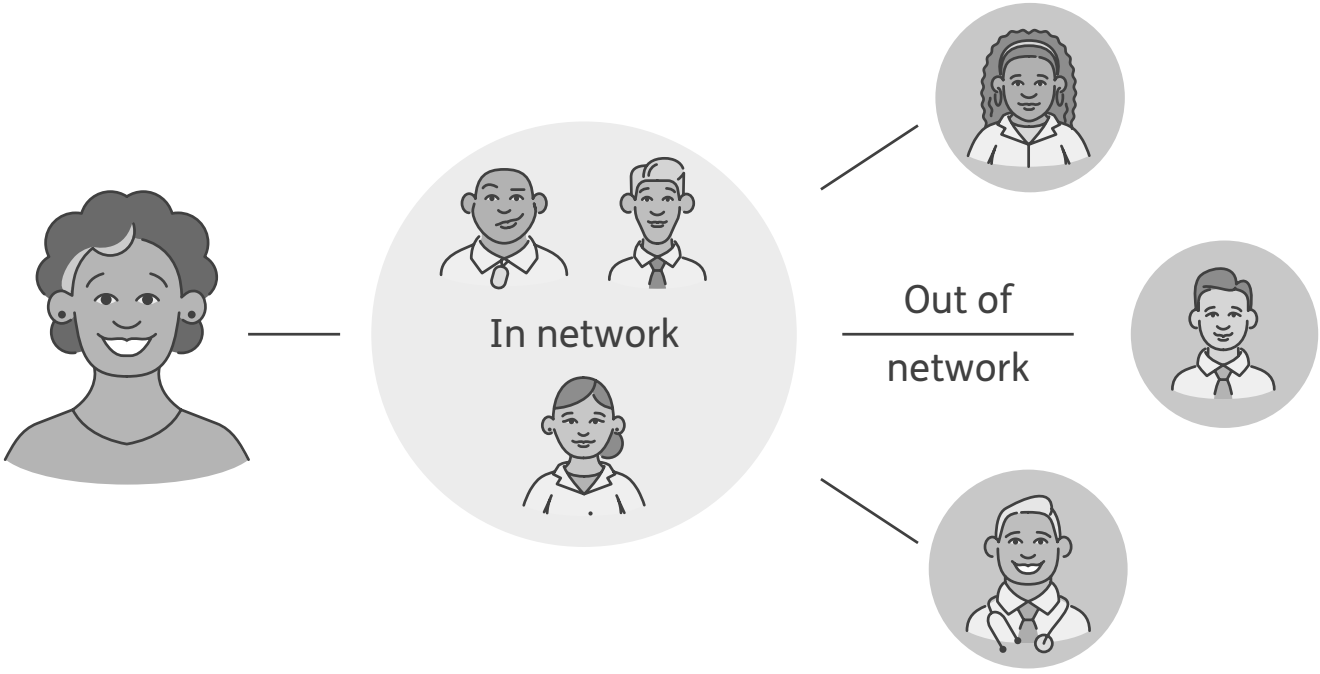
Preferred provider organization (PPO) plans give you the freedom to get care in or out of network. Your PPO plan may have a higher premium (monthly payment) than a health maintenance organization, or HMO, plan. However, copays and coinsurance can be more predictable.

Your Dual Eligible Special Needs plan, also called a DSNP, coordinates the benefits of Medicaid and Medicare Parts A and B.

Extra Help is a government program that can help you pay for medicine. If you're eligible for Extra Help, your drug coverage works with it to lower your prescription costs.

Using a PPO plan

- PPO plans may offer emergency coverage when you travel worldwide.
- Your Dual Eligible Special Needs plan, also called a DSNP, coordinates the benefits of Medicaid and Medicare Parts A and B.
- There may be higher cost sharing if you receive care from out-of-network providers, except for emergency care. In some cases, the costs are the same in and out of network.

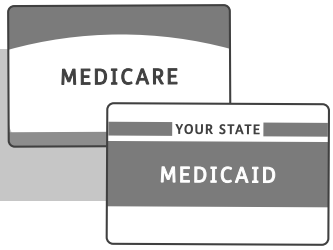


Understanding your Medicare options

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

If you're eligible for both, enroll in Original Medicare and Medicaid—offered by the government.



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

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

Medicaid offers benefits that Medicare doesn't normally cover, like nursing home care and personal care services.

Step 2

After enrolling in Original Medicare and Medicaid, you can enroll in a Medicare Advantage DSNP with additional coverage—offered by private companies.

Medicare Part C (Medicare Advantage) is made up of Part A, Part B and may include Part D (prescription drug benefits).* It may also give you extra benefits like hearing, dental and vision.

Ask your licensed sales agent about other plan types that may be available to you.

* 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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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.

Healthy Options allowance

All our DSNPs give you a Healthy Options allowance. The allowance is loaded to your Humana Spending Account Card each month. You can use your card at approved retailers to help pay for eligible items. That includes groceries, rent or mortgage payments, utility bills, over-the-counter products, pet food and much more. On all Humana DSNPs, whatever you don't use gets rolled over to the next month.

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

Our dental coverage includes two cleanings per year, an annual exam, fillings 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.

The Humana difference

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.

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**.

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.**

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

Extra Help

Extra Help is a government program that helps some people pay for their prescriptions. It's also called the Low-Income Subsidy, or LIS. You may be able to use it for Medicare prescription drug program costs like premiums, deductibles and coinsurance.

→ To learn more or apply, contact:

Medicare
1-800-MEDICARE (1-800-633-4227)
(TTY: 1-877-486-2048)
24 hours a day, 7 days a week
www.medicare.gov

The Social Security Administration
800-772-1213 (TTY: 800-325-0778)
Monday – Friday, 7 a.m. – 7 p.m.,
Eastern time

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 plan: H0028-064. Please refer to the Summary of Benefits to learn if your plan includes Go365 by Humana.

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

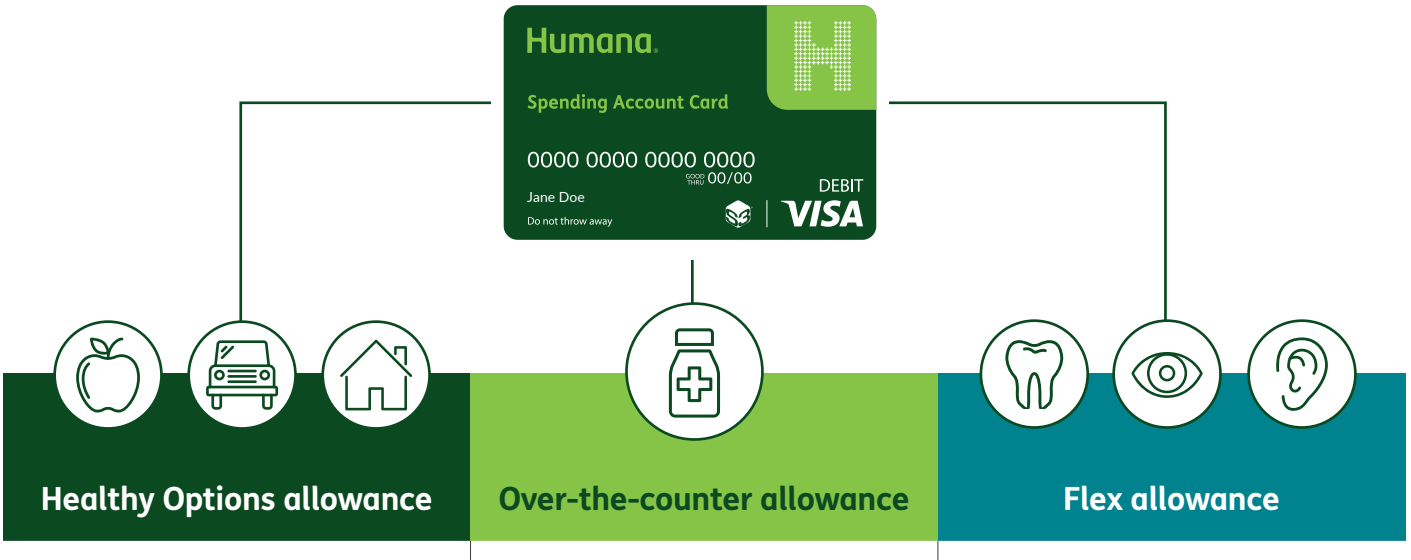
Go365 by Humana is offered on most plans at no extra charge.

† 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.

Humana Spending Account Card

One card, **up to three allowances**

The Humana Spending Account Card lets you access up to three of the plan benefit allowances shown below, depending on what benefits you have on your plan. You can use your allowances to help you pay for eligible items and covered services at participating retailers. To see your plan's available benefits, allowances, allowance amounts and how often they're loaded to your card, review your plan's Summary of Benefits.



Healthy Options allowance

The **Healthy Options allowance** is designed to help you get the daily essentials you need. Use it for:

- **Healthy food**
- **Over-the-counter items**
- **Rent or mortgage**
- **Internet and utilities**
- **Home and personal supplies**
- **Pet care**
- **Assistive devices**
- **Pest control**

Over-the-counter allowance

Use your **Over-the-counter (OTC) allowance** at participating network retailers, including CenterWell Pharmacy®, for items like:

- **OTC medicines like pain relievers and cough drops**
- **Toothbrushes, toothpaste and denture cream**
- **Cleansing wipes and bladder control pads**
- **Bandages and first aid supplies**
- **Vitamins and minerals**

Flex allowance

The **Flex allowance** can be used toward plan-covered dental, vision and hearing services at participating providers whose primary business is dental, vision or hearing and that accept Visa®. You could use your allowance to help pay for:

- **Dental cleanings**
- **Eye exams**
- **Glasses and contacts**
- **Hearing exams and hearing aids**
- **Copays and coinsurance on dental, vision and hearing services covered by the plan**

Call a licensed Humana sales agent to learn more

Humana®

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

Humana is a Medicare Advantage HMO, HMO SNP, PPO, PPO SNP 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.

These allowance types and amounts vary by plan and location. If your plan includes multiple allowances, the allowances cannot be combined. No amounts on the Healthy Options allowance can be used to purchase Medicare-covered prescriptions or services, nor can it be converted to cash. Other restrictions and limitations may apply.

* The Healthy Options allowance balance may roll over month to month in the following markets: Arkansas, Iowa, Missouri, Montana, Nebraska, Oklahoma, South Dakota, Utah, Washington, Wisconsin, Wyoming.

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。

2024 **Health Plan Benefits** at a Glance

HumanaChoice SNP-DE H5970-020 (PPO D-SNP) Upstate New York

Plan Costs	
Monthly plan premium	$0
Part B deductible *You pay the same amount as you would with Original Medicare. In 2023, the amounts are as listed. These amounts may change in 2024.	$0 or $226 combined* The following services listed are excluded from the combined in-network and out-of-network Part B deductible: In-Network only: Ambulance Services Chemotherapy Drugs and Administration Diabetic Monitoring Supplies Medicare Part B Covered Drugs Part A Services (IP, Skilled Nursing and Home Health) Both In-Network and Out-of-Network: Emergency Room Services Medicare Covered Preventive Services Services not covered by Original Medicare Urgently Needed Services at Urgent Care Centers
Annual out-of-pocket maximum	$8,850 in-network $13,300 combined in and out-of-network If you are eligible for Medicare cost-sharing assistance under the New York State Department of Health (SDOH)(Medicaid), 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	**Out-of-Network**
Doctor Office Visits		
Primary care provider (PCP)	$0 copay	$0 or 30% of the cost
Specialist	$0 copay	$0 or 30% of the cost
Preventive Care		
Including: Medicare covered screenings	Covered at no cost	Preventive screenings may have a cost share when you see an out-of-network provider.
Telehealth Services (in addition to Original Medicare)		
Primary care provider (PCP)	$0 copay	Not covered
Specialist	$0 copay	Not covered

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Telehealth Services (in addition to Original Medicare)		
Urgent care services	$0 copay	Not covered
Substance abuse or behavioral health services	$0 copay	Not covered
Inpatient Care		
Acute inpatient hospital care	$0 copay	$0 or 30% of the cost
Lab Services		
Lab tests from lab facility	$0 copay	$0 or 30% of the cost
Lab tests from outpatient hospital facility	$0 copay	$0 or 30% of the cost
Outpatient Care		
Outpatient surgery at ambulatory surgical center	$0 copay	$0 or 30% of the cost
Physical therapy at therapy facility	$0 copay	$0 or 30% of the cost
X-rays at outpatient hospital facility	$0 copay	$0 or 30% of the cost
Diagnostic testing at outpatient hospital facility	$0 copay	$0 or 30% of the cost
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.	$0 copay	$0 or 30% of the cost
Specialist's office	$0 copay	$0 or 30% of the cost
Outpatient hospital	$0 copay	$0 or 30% of the cost
Partial hospitalization	$0 copay	$0 or 30% of the cost
Emergency Services		
Urgently needed services at an urgent care center	$0 copay	$0 or $55 copay
Ambulance services	$0 copay	$0 or $300 copay per date of service
Emergency room	$0 copay	$0 or $100 copay

Additional Benefits & Programs	
Healthy Options Allowance	**$200** monthly allowance on a prepaid card to use for essentials you need to support your health. This allowance can be used to buy approved products from participating retail locations (like groceries, over-the-counter health and wellness items, personal care items, home supplies, etc.) or pay for approved services (monthly living expenses like rent, non-medical transportation costs like a taxi, Uber, Lyft, etc.). Allowance amount cannot be combined with other allowances which may be on the Card. Unused funds will roll over to the next month and expire at the end of the plan year.
Mandatory supplemental dental benefit DEN283	Included
Mandatory supplemental vision benefit VIS692	Included
Mandatory supplemental hearing benefit HER945	Included
Transportation	**$0** copay for plan approved location up to 48 one-way trip(s) per year. This benefit is not to exceed 25 miles per trip.
Humana Well Dine® meal program	Included
Post Discharge Personal Home Care Services	Included
SilverSneakers® fitness program	Included
Smoking Cessation	Included
Wigs	Included - cost share may apply. Please refer to the Summary of Benefits for additional details.

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2024 **Prescription Drug Benefits** at a Glance

HumanaChoice SNP-DE H5970-020 (PPO D-SNP) Upstate New York

Plan Highlights	
$0 Rx Copay Benefit	If you receive "Extra Help", you will pay **$0** for all Medicare Part D covered prescription drugs on your formulary for the entire calendar year.
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

If you do not receive "Extra Help" refer to Chapter 6 of the Evidence of Coverage for more details on the prescription drug benefit.

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

Some drugs are limited to a 30-day supply

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 Coordinated Care (PPO D-SNP) plan with a Medicare contract and a contract with the New York State Department of Health (SDOH)(Medicaid) program. Enrollment in this Humana plan depends on contract renewal.

Your provider may choose to submit to the New York State Department of Health (SDOH)(Medicaid) for consideration of additional secondary payment for an amount applied to deductibles, coinsurance, or copayments. Providers are required by federal regulation to accept HumanaChoice SNP-DE H5970-020 (PPO D-SNP) primary payment and the New York State Department of Health (SDOH)(Medicaid) secondary payment as payment in full for covered Medicare Part A and Part B services – even when the Medicaid payment is zero or a provider chooses to not submit to Medicaid.

If you are cost-share protected by the New York State Department of Health (SDOH)(Medicaid), HumanaChoice SNP-DE H5970-020 (PPO D-SNP) providers aren't allowed to collect or bill you for services and items covered under Medicare Part A and Part B, including deductibles, coinsurance, and copayments – even when Medicaid payment is zero or a provider chooses to not submit to Medicaid. If a provider asks you to pay, that's against the law. You may however be responsible for a small Medicaid copayment.

If you are cost-share protected and you are billed or asked to pay the provider for deductibles, coinsurance, or copayments on covered Medicare Part A and Part B services tell your provider you are cost-share protected and can't be charged. If you have already made payment you have the right to a refund. If your provider will not stop billing, you can call Customer Care at 1-800-457-4708 or you can call Medicare at 1-800-Medicare (1-800-633-4227), (TTY 1-877-486-2048). Customer Care or Medicare can ask your provider to stop billing you and refund any payment you have made.

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.

Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

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

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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.

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2024

Summary of Benefits

HumanaChoice SNP-DE H5970-020 (PPO D-SNP)

Upstate New York
Select Counties in New York

Our service area includes the following county/counties in New York: Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Columbia, Cortland, Delaware, Dutchess, Erie, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Ulster, Warren, Washington, Westchester, Wyoming, Yates.

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. The Part A/ Part B premiums may be paid for by the New York State Department of Health (SDOH) (Medicaid).
- ☐ 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.
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. This plan may enroll FBDE, QMB, QMB+.

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Let's talk about HumanaChoice SNP-DE H5970-020 (PPO D-SNP)

Find out more about the HumanaChoice SNP-DE H5970-020 (PPO D-SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice SNP-DE H5970-020 (PPO D-SNP) is a Coordinated Care plan LPPO with a Medicare contract and a contract with the New York State Department of Health (SDOH) (Medicaid) program. 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**.

As a member, it's a good idea to select a doctor as your Primary Care Provider(PCP). HumanaChoice SNP-DE H5970-020 (PPO D-SNP) has a network of doctors, hospitals, pharmacies and other providers.

You have access to Care Managers. Care Managers are nurses or care coordinators who support your health and well-being by providing additional services including acute and chronic-care management, telephonic and in-person health support, assistance in coordinating Medicare and Medicaid benefits, educational resources and workshops, and support for families and caregivers.

To be eligible

To enroll in HumanaChoice SNP-DE H5970-020 (PPO D-SNP), a Dual Eligible Special Needs Plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B, live in our service area and also receive certain levels of assistance from the New York State Department of Health (SDOH) (Medicaid). If you receive both Medicare and Medicaid benefits, this means you are dual eligible.

HumanaChoice SNP-DE H5970-020 (PPO D-SNP) may enroll FBDE, QMB, QMB+.

Full Benefit Dual Eligible (FBDE): Financial assistance may be available to pay Medicare Part A Premiums, and/or Medicare Part B Premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

Qualified Medicare Beneficiary (QMB): Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).

Qualified Medicare Beneficiary Plus (QMB+): Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

Plan name:

HumanaChoice SNP-DE H5970-020 (PPO D-SNP)

More about HumanaChoice SNP-DE H5970-020 (PPO D-SNP)

Depending on your level of eligibility for assistance under your state Medicaid program, you may or may not be subject to cost-sharing requirements. The Medicaid Benefit Comparison chart shows specific benefits that Medicaid may cover for some dual eligible members. You will work with your Humana care coordinator to understand and access these benefits. The Covered Medical and Hospital Benefits chart shows the benefits you will receive from Humana.

Be sure to show the New York State Department of Health (SDOH) (Medicaid) ID card in addition to your Humana membership card to make your provider aware that you also have Medicaid coverage. You may be required to pay a small Medicaid specific co-payment. Your services are paid first by Humana and then by Medicaid.

How to reach us:

If you have questions about your benefits or your level of eligibility for assistance from Medicaid, you should contact Humana's Customer Care department or the New York State Department of Health (SDOH) (Medicaid) for further details.

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**.

Medicaid benefits last validated on 07/01/2023 and are subject to change. For the most current New York Medicaid coverage information, please visit the New York State Department of Health (SDOH) (Medicaid) website at **https://www.health.ny.gov/health_care/medicaid/members/** or call the Medicaid Hotline at 1-800-541-2831 (toll free) .

A healthy partnership

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

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Monthly Premium, Deductible and Limits

Monthly plan premium	**$0** You must keep paying your Medicare Part B premium. Your Part A and/or Part B premium may be paid on your behalf by the New York State Department of Health (SDOH) (Medicaid) Program.
Medical deductible * You pay the same amount as you would with Original Medicare. In 2023, the amounts are as listed. These amounts may change in 2024.	**$0** or **$226*** combined in-network and out-of-network deductible for Part B services, depending on your level of Medicaid eligibility. The following services listed are excluded from the combined in-network and out-of-network Part B deductible: In-Network only: Ambulance Services Chemotherapy Drugs and Administration Diabetic Monitoring Supplies Medicare Part B Covered Drugs Part A Services (IP, Skilled Nursing and Home Health) Both In-Network and Out-of-Network: Emergency Room Services Medicare Covered Preventive Services Services not covered by Original Medicare Urgently Needed Services at Urgent Care Centers
Pharmacy (Part D) deductible	**$0** deductible if you receive "Extra Help".
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for covered medical services for the year	**$8,850** in-network **$13,300** combined in- and out-of-network If you are eligible for Medicare cost-sharing assistance under the New York State Department of Health (SDOH) (Medicaid) 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.

Covered Medical and Hospital Benefits

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
INPATIENT HOSPITAL CARE		
	$0 copay	**$0** or **30%** of the cost
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)	**$0** copay	**$0** or **30%** of the cost

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
Basic radiological services (X-rays)	**$0** copay	**$0** or **30%** of the cost
Cardiac rehabilitation services	**$0** copay	**$0** or **30%** of the cost
Chemotherapy drugs	**$0** copay	**$0** or **30%** of the cost
Diagnostic colonoscopy	**$0** copay	**$0** or **30%** of the cost
Diagnostic mammography	**$0** copay	**$0** or **30%** of the cost
Diagnostic procedures and tests - other	**$0** copay	**$0** or **30%** of the cost
Lab services	**$0** copay	**$0** or **30%** of the cost
Medicare Part B covered drugs	**$0** copay	**$0** or **30%** of the cost
Mental health services	**$0** copay	**$0** or **30%** of the cost
Nuclear medicine services	**$0** copay	**$0** or **30%** of the cost
Occupational therapy	**$0** copay	**$0** or **30%** of the cost
Opioid treatment program services	**$0** copay	**$0** or **30%** of the cost
Physical therapy	**$0** copay	**$0** or **30%** of the cost
Pulmonary rehabilitation services	**$0** copay	**$0** or **30%** of the cost
Renal dialysis services	**$0** copay	**$0** or **20%** of the cost
Sleep study (facility based)	**$0** copay	**$0** or **30%** of the cost
Speech therapy	**$0** copay	**$0** or **30%** of the cost
Substance abuse services	**$0** copay	**$0** or **30%** of the cost
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)	**$0** copay	**$0** or **30%** of the cost
Surgery services	**$0** copay	**$0** or **30%** of the cost
Therapeutic radiology (Radiation therapy)	**$0** copay	**$0** or **30%** of the cost
Wound care	**$0** copay	**$0** or **30%** of the cost
AMBULATORY SURGERY CENTER		
Diagnostic colonoscopy	**$0** copay	**$0** or **30%** of the cost
Surgery services	**$0** copay	**$0** or **30%** of the cost

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**$0** or **30%** of the cost
Specialist	**$0** copay	**$0** or **30%** of the cost
PREVENTIVE CARE		
	Our plan covers many preventive services at no cost including: • Abdominal aortic aneurysm screening • Alcohol misuse screening & counseling • Annual Wellness Visit (AWV) • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit • Cardiovascular disease screenings • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • 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 exams • Routine Physical Exam • Sexually transmitted infections (STIs) screening and counseling	**$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.

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
	• 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 room If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	**$0** copay	**$0** or **$100** copay
Physician and professional services at emergency room	**$0** copay	**$0** copay
URGENTLY NEEDED SERVICES		
Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$0** copay	**$0** or **$55** copay at an urgent care center
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Advanced imaging services (MRI, MRA, PET and CT scan)		
• Freestanding radiological facility	**$0** copay	**$0** or **30%** of the cost
• Primary care physician's office	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
Basic radiological services (X-rays)		
• Freestanding radiological facility	**$0** copay	**$0** or **30%** of the cost
• Primary care physician's office	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
• Urgent care center	**$0** copay	**$0** or **$55** copay

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
Diagnostic colonoscopy at an ambulatory surgery center	**$0** copay	**$0** or **30%** of the cost
Diagnostic mammography		
• Freestanding radiological facility	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
Diagnostic procedures and tests		
• Primary care physician's office	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
• Urgent care center Diagnostic tests and procedures	**$0** copay	**$0** or **$55** copay
Lab services		
• Freestanding laboratory	**$0** copay	**$0** or **30%** of the cost
• Primary care physician's office	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
• Urgent care center	**$0** copay	**$0** or **$55** copay
Nuclear medicine and services at a freestanding radiological facility	**$0** copay	**$0** or **30%** of the cost
Sleep study		
• Member's home	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
Therapeutic radiology (Radiation therapy)		
• Freestanding radiological facility	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**$0** copay	**$0** or **30%** of the cost
Mandatory supplemental hearing benefit	**HER945** • **$0** copay for routine hearing exams up to 1 per year. • **$0** copay for each Advanced level hearing aid up to 1 per ear every 3 years. Hearing aid purchase includes: • Unlimited follow-up provider visits during first year following	

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
	TruHearing hearing aid purchase • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models • Rechargeable style options available. **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		
Medicare-covered dental	**$0** copay	**$0** or **30%** of the cost
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	**DEN283** • **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. • **$0** copay for complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years. • **$0** copay for crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime. • **$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • **$0** copay for adjustments to dentures, denture rebase,	**DEN283** • **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. • **$0** copay for complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years. • **$0** copay for crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime. • **$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • **$0** copay for adjustments to dentures, denture rebase,

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

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	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
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 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) 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	denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year. • **$0** copay for emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **$0** copay for periodontal maintenance up to 4 per year. • **$0** copay for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. • **$1,000** combined maximum benefit coverage amount per year for all preventive and comprehensive benefits.	denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year. • **$0** copay for emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **$0** copay for periodontal maintenance up to 4 per year. • **$0** copay for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. • **$1,000** combined maximum benefit coverage amount per year for all preventive and comprehensive benefits. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
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.		
VISION SERVICES		
Eyewear (post cataract surgery)	**$0** copay	**$0** or **30%** of the cost
Medicare-covered diabetic eye exam	**$0** copay	**$0** or **30%** of the cost
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.	**$0** copay	**$0** or **30%** of the cost
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 the Vision Care	**VIS692** • **$0** copay for routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for routine exam. • **$150** maximum benefit coverage amount per year for contact lenses or	**VIS692** • **$0** copay for routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for routine exam. • **$150** maximum benefit coverage amount per year for contact lenses or

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
icon > select Medicare > select Medicare Advantage.	eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • **$200** 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.	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	**$0** copay	**$0** or **30%** of the cost
Therapy visits		
• Partial hospitalization	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
SKILLED NURSING FACILITY		
Your plan covers up to 100 days in a SNF	**$0** copay	**$0** or **30%** of the cost for days 1-100
PHYSICAL THERAPY		
Comprehensive outpatient rehab facility	**$0** copay	**$0** or **30%** of the cost
Specialist's office	**$0** copay	**$0** or **30%** of the cost

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
AMBULANCE		
	$0 copay	**$0** or **$300** copay per date of service
TRANSPORTATION		
	$0 copay for plan approved location up to 48 one-way trip(s) per year. This benefit is not to exceed 25 miles per trip. The member *must* contact transportation vendor to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider.	
MEDICARE PART B DRUGS		
Allergy shots and serum		
• Primary care physician's office	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
Chemotherapy drugs at a specialist's office	**$0** copay	**$0** or **30%** of the cost
Other Part B drugs		
• Pharmacy	**$0** copay	**$0** copay
• Primary care physician's office	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

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Prescription Drug Benefits

PLAN HIGHLIGHTS	
$0 Rx Copay Benefit	If you receive "Extra Help", you will pay **$0** for all Medicare Part D covered prescription drugs on your formulary for the entire calendar year.
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

If you do not receive "Extra Help" refer to Chapter 6 of the Evidence of Coverage for more details on the prescription drug benefit.

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

Some drugs are limited to a 30-day supply

Additional Benefits

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
Chiropractic services (Medicare-covered)	**$0** copay	**$0** or **30%** of the cost
Podiatry services (Medicare-covered)	**$0** copay	**$0** or **30%** of the cost
Acupuncture services (Medicare-covered)	**$0** copay	**$0** or **30%** coinsurance 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	**$0** copay	**$0** or **20%** of the cost
• Network retail pharmacy	**$0** copay	**$0** copay
• Preferred diabetic supplier	**$0** copay	**Not Covered**
Durable medical equipment (DME) and related supplies	**$0** copay	**$0** or **30%** of the cost
Medical Supplies at medical supplier	**$0** copay	**$0** or **30%** of the cost

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
Prosthetic devices and related supplies	**$0** copay	**$0** or **30%** of the cost
REHABILITATION SERVICES		
Cardiac rehabilitation services at a specialist's office	**$0** copay	**$0** or **30%** of the cost
Occupational therapy		
• Comprehensive outpatient rehab facility	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
Physical therapy		
• Comprehensive outpatient rehab facility	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
Pulmonary rehabilitation services at a specialist's office	**$0** copay	**$0** or **30%** of the cost
Speech therapy		
• Comprehensive outpatient rehab facility	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD) at a specialist's office	**$0** copay	**$0** or **30%** of the cost
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care physician's office	**$0** copay	**Not Covered**
Specialist's office	**$0** copay	**Not Covered**
Substance abuse or behavioral health services	**$0** copay	**Not Covered**
Urgent care services	**$0** copay	**Not Covered**

Medicaid Benefit Comparison

The benefits described in the Covered Medical and Hospital Benefits sections above are covered by HumanaChoice SNP-DE H5970-020 (PPO D-SNP). Below is a comparison of benefits that some Medicaid eligible individuals could receive directly from the New York State Department of Health (SDOH) (Medicaid). For each benefit listed below, you can see what the New York State Department of Health (SDOH) (Medicaid) covers and what our plan covers. All Medicaid benefits are subject to Medicaid eligibility guidelines and requirements and are available only to full dual eligible individuals. If you have questions about your Medicaid eligibility, what benefits you are entitled to, and any cost-sharing you may be responsible for, review your member handbook or contact the New York State Department of Health (SDOH) (Medicaid) at 1-800-541-2831 (toll free).

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Inpatient hospital care	**$25** copay per admit	Covered
Ambulance	Covered	Covered
Ambulatory surgical center	**$3** copay per visit	Covered
Dentures	Covered	Covered
Diagnostic services, labs, and imaging	**$0.50** copay per procedure	Covered
Doctor office visits	**$0** copay	Covered
Emergency care	**$3** copay per visit	Covered
Eyeglasses	Covered	Covered
Hearing aids	Covered	Covered
Home and community based waiver service programs	Covered	Not Covered
Inpatient hospital, nursing facility and intermediate care facility services in institutions for mental diseases (MD), age 65 and older	Covered	Covered with limitations
Inpatient psychiatric services, under age 21	Covered	Covered with limitations
Intermediate care facilities for individuals with intellectual disabilities (ICFs-IID)	Covered	Not Covered
Mental health services	Covered	Covered
Nursing facility services, other than in an institution for mental diseases	Covered	Covered with limitations

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Outpatient hospital coverage	Covered	Covered
Physical, occupational, speech therapy	Covered	Covered
Medicare Part B drugs	Covered	Covered
Preventive care	Covered	Covered
Transportation	Covered	Covered
Skilled nursing facility	Covered	Covered
Urgently needed services	Covered	Covered
Durable medical equipment	Covered	Covered
Home health care services	**$0** copay	Covered with limitations
Prosthetic devices	Covered	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**.

Healthy Options Allowance

$200 monthly allowance on a prepaid card to use for essentials you need to support your health.

This allowance can be used to buy approved products from participating retail locations (like groceries, over-the-counter health and wellness items, personal care items, home supplies, etc.) or pay for approved services (monthly living expenses like rent, non-medical transportation costs like a taxi, Uber, Lyft, etc.).

Allowance amount cannot be combined with other allowances which may be on the Card.

Unused funds will roll over to the next month and expire at the end of the plan year.

- Allowance is available to use at the beginning of every month.
- Limitations and restrictions may apply.

See the Humana Spending Account Card section for more information.

Humana Spending Account Card

The Humana Spending Account Card is what you use to spend allowances included in this plan. If your previous plan had a Humana Spending Account Card, please keep using the same card. If your previous plan did not have a Humana Spending Account Card, please activate your card as soon as you receive it in the mail.

Please keep this card even after the allowance is spent as future allowance amounts will be added to this card.

- Humana is not responsible for funds lost due to lost or stolen cards.
- Please see the back of your card for more information.
- Allowance amounts cannot be combined with other benefit allowances on the card.
- Limitations and restrictions may apply.

Travel Coverage

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

Smoking cessation program
To further assist in your effort to quit smoking or tobacco product use, we cover one additional counseling quit attempt within a 12-month period as a service with no cost to you. This is in addition to the two counseling attempts provided by Medicare and includes up to four face-to-face visits. This service can be used for either preventive measures or for diagnosis with a tobacco related disease.

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

Post Discharge Personal Home Care
$0 copay for a minimum of 4 hours per day, up to a maximum of 44 hours per year for certain in-home support services following a discharge from a skilled nursing facility or from an inpatient hospitalization.

Qualified aides can offer assistance performing activities of daily living (ADLs) and Instrumental Activities of Daily living (IADLs) within the home.

Activities of daily living are activities related to personal care.

They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.

Instrumental Activities of Daily Living are activities related to independent living.

They include preparing meals, pick up pre-paid curbside/drive-through orders, performing light housework, laundry, dishes, and/or using a telephone.

A member must be receiving assistance with a minimum of one ADL to receive assistance with any IADL.

Services must be initiated within 30 days of discharge event and utilized within 60 days of discharge for each qualifying event up to the maximum annual allowance.

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

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Wigs (related to chemotherapy treatment)
Up to a **$500** combined in and out of network maximum benefit per year.

SilverSneakers® fitness program
Basic fitness center membership including in person and digital fitness classes.

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 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

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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。

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

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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.

Humana has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2026 based on a review of Humana's Model of Care.

Your provider may choose to submit to the New York State Department of Health (SDOH) (Medicaid) for consideration of additional secondary payment for an amount applied to deductibles, coinsurance, or copayments. If you are Cost Share Protected, providers are required by federal regulation to accept HumanaChoice SNP-DE H5970-020 (PPO D-SNP) primary payment and the New York State Department of Health (SDOH) (Medicaid) secondary payment as payment in full for covered Medicare Part A and Part B services – even when the Medicaid payment is zero or a provider chooses to not submit to Medicaid.

If you are cost-share protected by the New York State Department of Health (SDOH) (Medicaid), HumanaChoice SNP-DE H5970-020 (PPO D-SNP) providers aren't allowed to collect or bill you for services and items covered under Medicare Part A and Part B, including deductibles, coinsurance, and copayments – even when Medicaid payment is zero or a provider chooses to not submit to Medicaid. If a provider asks you to pay, that's against the law. You may however be responsible for a small Medicaid copayment.

If you are cost-share protected and you are billed or asked to pay the provider for deductibles, coinsurance, or copayments on covered Medicare Part A and Part B services tell your provider you are cost-share protected and can't be charged. If you have already made payment you have the right to a refund. If your provider will not stop billing, you can call us at 1-800-457-4708 or you can call Medicare at 1-800-Medicare (1-800-633-4227), (TTY 1-877-486-2048). Humana or Medicare can ask your provider to stop billing you and refund any payment you have made.

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.

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.

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.

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

H5970_SB_MAPD_PPO_020000_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/20PDG492** 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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  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents**: You may also call California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

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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

Dual Eligible Special Needs Plan Enrollment Form

Use this form **ONLY** if you are enrolling into a Humana Dual Eligible Special Needs Plan.

Follow these easy steps to become a Humana Medicare member

Have both your Medicare and Medicaid cards 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: **1-877-889-9923**. 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.

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

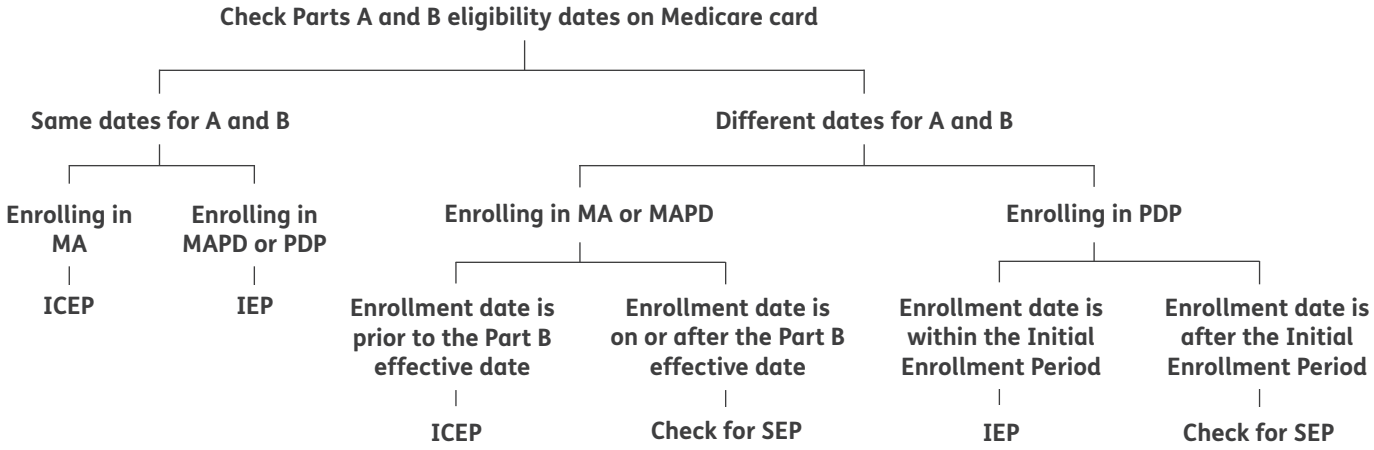
Asterisks (*) indicate required fields
Answering non-required fields is your choice. You can't be denied coverage if you don't complete them.

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. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare Advantage health plan or prescription drug plan. 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.** 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 **Dual Eligible Special Needs Plan (D-SNP)**, the following statement applies: I understand this plan is for individuals with both Medicaid and Medicare. My ability to enroll is based on verification that I am entitled to both Medicare and medical assistance under Medicaid.

  For **FLORIDA** enrollees of a D-SNP: I understand that this plan is sponsored by Humana and the State of Florida Agency For Health Care Administration.

  For **TENNESSEE** enrollees of a D-SNP: I understand that TennCare is not responsible for payment for these benefits, except for appropriate cost sharing amounts. TennCare is not responsible for guaranteeing the availability or quality of these benefits. Any reference to more, extra or additional Medicare benefits, is applicable to Medicare only and does not indicate increased Medicaid benefits.
- I understand that I am enrolling into a Humana Medicare Advantage 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 Dual Eligible Special Needs Plan 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 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 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 D-SNP
- Humana Community HMO D-SNP
- Humana Fully Integrated HMO D-SNP (Humana Long Term Care Plan Required)
- Humana Gold Plus® Integrated HMO D-SNP
- HumanaChoice® PPO D-SNP
- Humana Care Extra PPO D-SNP
- HumanaChoice® Integrated PPO D-SNP

Medicaid eligibility is required for all Dual Eligible Special Needs Plans.

MEDICAID NUMBER

By marking this oval, I attest that I have received award materials for a future Medicaid effective date.

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

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, Mexican, Mexican American, Chicano/a
◯ Yes, Puerto Rican
◯ Yes, Cuban
◯ Yes, another Hispanic, Latino/a, or Spanish origin
◯ I choose not to answer

What's your race? Select all that apply.

◯ American Indian or Alaska Native
◯ Asian Indian
◯ Black or African American
◯ Chinese
◯ Filipino
◯ Guamanian or Chamorro
◯ Japanese
◯ Korean
◯ Native Hawaiian
◯ Other Asian
◯ Other Pacific Islander
◯ Samoan
◯ Vietnamese
◯ White
◯ 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®

Humana.com

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 - H5970

For 2023, Humana - H5970 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★★☆
Health Services Rating:	★★★★½
Drug Services Rating:	★★★★☆

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

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

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

Star Ratings are based on factors that include:

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

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

The number of stars show how well a plan performs.

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

Get More Information on Star Ratings Online

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

Questions about this plan?

Contact Humana 7 days a week from 8:00 a.m. to 8:00 p.m. local time at 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 **855-599-5751 (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.

Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

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

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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