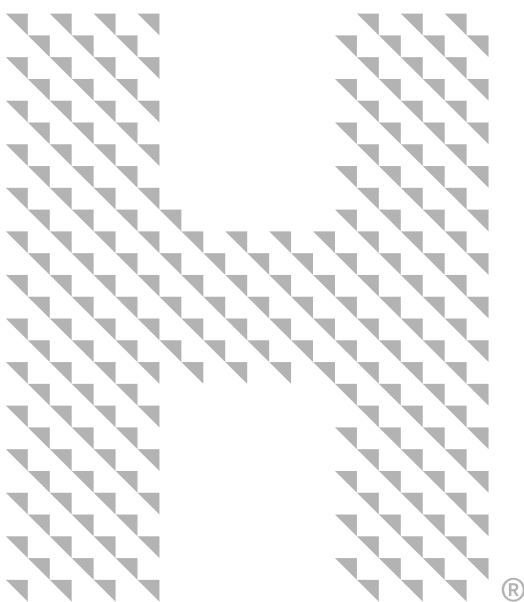


# PPO

Humana Full Access  
H5216-011-000  
Select Counties in MI  
H5216011000MAPDEN26PODPPPOF

MI:Alcona, Allegan, Alpena, Antrim, Arenac, Barry, Bay, Benzie, Berrien, Branch, Calhoun, Cass, Charlevoix, Cheboygan, Chippewa, Clare, Clinton, Crawford, Delta, Dickinson, Eaton, Emmet, Genesee, Gladwin, Gogebic, Grand Traverse, Gratiot, Hillsdale, Houghton, Huron, Ingham, Ionia, Josco, Isabella, Jackson, Kalamazoo, Kalkaska, Kent, Keweenaw, Lake, Lapeer, Leelanau, Lenawee, Livingston, Macomb, Marquette, Mason, Mecosta, Menominee, Midland, Missaukee, Monroe, Montcalm, Montmorency, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Oscoda, Otsego, Ottawa, Presque Isle, Roscommon, Saginaw, Sanilac, Shiawassee, St. Clair, St. Joseph, Van Buren, Washtenaw, Wayne, Wexford



# Enrollment book

**2026 MAPD**

**Medicare Advantage  
Prescription Drug Plan**

**The care you deserve**  
so you can focus on your health

# Humana®

Humana®

2026 MAPD

## Being in tune with you and delivering what you need

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

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



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



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



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



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



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

### Decades of experience, at your service

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



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

**Humana.FindHelp.com**

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



# What's inside

H5216-011-000

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

## Your agent information

Agent name \_\_\_\_\_

Agent phone number \_\_\_\_\_

Agent email \_\_\_\_\_



### Let's talk

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

**Humana.**

## How this plan works

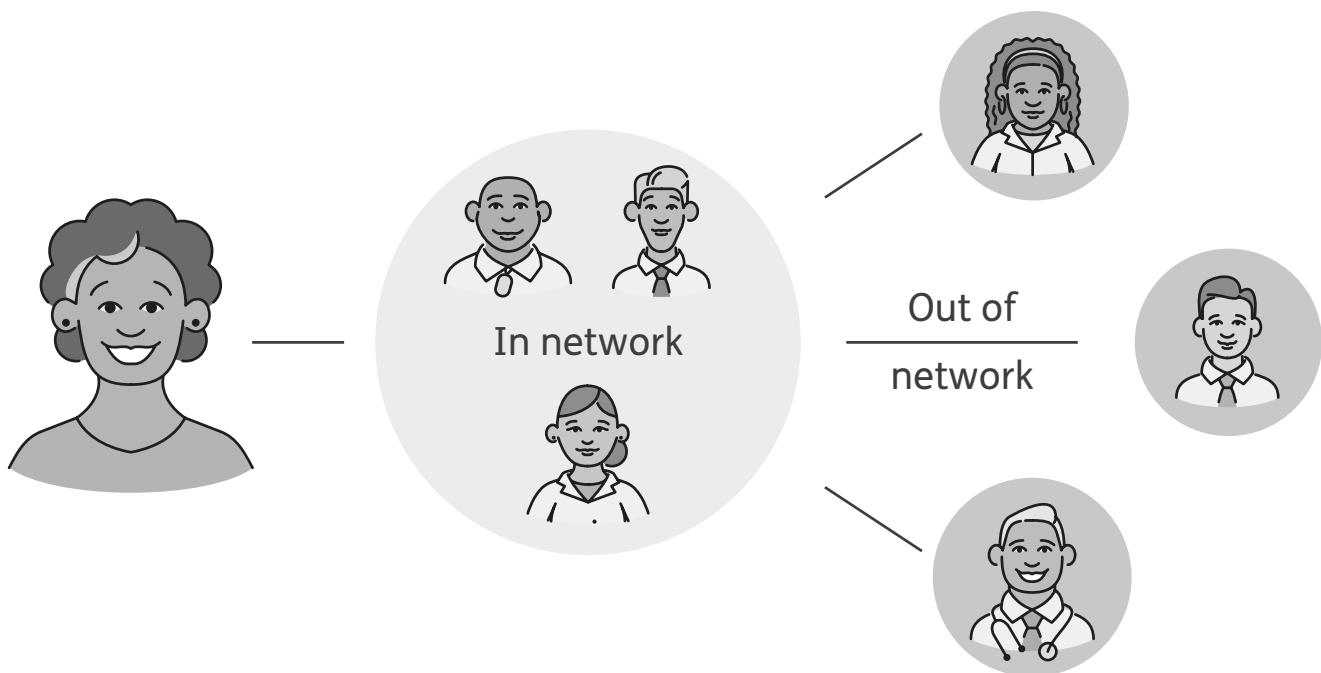
Here's how a PPO Medicare Advantage plan would work. (See all your Medicare options on the following page.)

### Preferred provider organization

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

### Using a PPO plan

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



# Understanding your Medicare options

Step

1

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



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



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

Step

2

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

**Option 1:** Choose a Medicare Advantage plan.

**OR**

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



## **Medicare Part C (Medicare Advantage)**

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



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



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



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



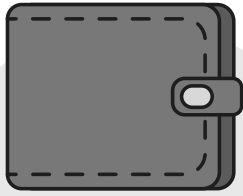
**Individual dental and vision plans or combined dental, vision and hearing plans** can help ensure coverage for all your healthcare needs.\*

\* Plans are not available in all states. Plan benefits may vary by state. Refer to the plan documents for complete details of coverage. Dental and vision plans, excluding Dental Savings Plus, may have a minimum one-year initial contract period. Payment may include an administration fee. Association membership and fees may be required on some plans in some states. A one-time, non-refundable enrollment fee may apply (the fee is non-refundable as allowed by state requirements). Applicable fees are disclosed at time of enrollment. These are not Medicare plans.

For Arizona: This is a solicitation of insurance. A licensed insurance agent/producer may contact you. For Texas: A person should not send money to the issuer in response to the advertisement and a person cannot obtain coverage under the health benefit plan without completing application for coverage.

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

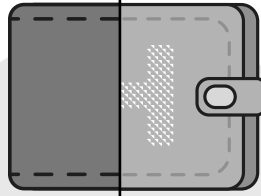
# Understanding the Part D Prescription Drug Stages



## STAGE 1

Deductible: **you pay 100%**

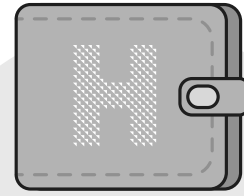
- A deductible is the amount you pay for your covered prescription drugs before the plan pays its share — you pay all costs until the deductible is met.
- Some plans may not have a deductible, allowing you to enter Stage 2 upon filling your first prescription of the year.
- Deductible amounts and tier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



## STAGE 2

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

- During the Initial Coverage Stage, you pay only your share of the cost (your copay or coinsurance amount) for covered prescription drugs while the plan pays the remaining cost.
- Both you and your insurance plan pay medication costs until your Part D out-of-pocket costs reach \$2,100.



## STAGE 3

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

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

# What's next after you enroll

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



**A notice confirming your application is approved**



**Your Humana member ID card**

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

## Get this information in your MyHumana account:

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



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





# Get health and wellness items you need

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

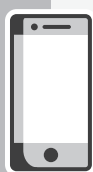
Save trips to the store with the over-the-counter (OTC) mail-order allowance included in this plan. You can use your allowance at CenterWell Pharmacy® to buy eligible OTC health and wellness products when you need them throughout the year.\*

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



## Order hundreds of OTC products, including:

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



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



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

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



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

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

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

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

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

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

# Summary of Benefits

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## **Humana Full Access H5216-011 (PPO)**

Michigan

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

## Pre-Enrollment Checklist

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

### Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **Humana.com/medicare** or call **800-833-2364 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary (Drug Guide) to make sure your drugs are covered.

### Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copays/coinsurance may change on January 1, 2027.
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ This plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copay/coinsurance for services received by non-contracted providers.



# Let's talk about Humana Full Access H5216-011 (PPO)

Find out more about the Humana Full Access H5216-011 (PPO) plan – including the health and drug services it covers – in this easy-to-use booklet.

Humana Full Access H5216-011 (PPO) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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

## To be eligible

To join Humana Full Access H5216-011 (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

## Plan name

Humana Full Access H5216-011 (PPO)

## How to reach us

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

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

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

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

## More about Humana Full Access H5216-011 (PPO)

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

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

As a member it's a good idea to select a doctor as your Primary Care Provider (PCP). Humana Full Access H5216-011 (PPO) has a network of doctors, hospitals, pharmacies and other providers.



## A healthy partnership

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



## Monthly Premium, Deductible and Limits

### PLAN COSTS

|                                                     |                                                                                                                                                                                    |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Monthly plan premium</b>                         | <b>\$18</b><br>If you receive premium assistance, this plan premium may be reduced.<br>You must keep paying your Medicare Part B premium.                                          |
| <b>Medical deductible</b>                           | This plan does not have a deductible.                                                                                                                                              |
| <b>Pharmacy (Part D) deductible</b>                 | <b>\$0</b> deductible for Tier 1, Tier 2 and Tier 3<br><b>\$300</b> deductible for Tier 4 and Tier 5                                                                               |
| <b>Medical Maximum out-of-pocket responsibility</b> | <b>\$5,700</b> in-network<br><b>\$5,700</b> combined in- and out-of-network<br>The most you pay for copays, coinsurance and other costs for covered medical services for the year. |



## Medical Benefits

|                                                                     | IN-NETWORK                                                                        | OUT-OF-NETWORK                                                                    |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| <b>INPATIENT HOSPITAL COVERAGE</b>                                  |                                                                                   |                                                                                   |
| This plan covers an unlimited number of days for an inpatient stay. | <b>\$350</b> copay per day for days 1-6<br><b>\$0</b> copay per day for days 7-90 | <b>\$350</b> copay per day for days 1-6<br><b>\$0</b> copay per day for days 7-90 |
| <b>OUTPATIENT HOSPITAL COVERAGE</b>                                 |                                                                                   |                                                                                   |
| <b>Diagnostic colonoscopy</b>                                       | <b>\$0</b> copay                                                                  | <b>\$0</b> copay                                                                  |
| <b>Diagnostic mammography</b>                                       | <b>\$0</b> copay                                                                  | <b>\$0</b> copay                                                                  |
| <b>Surgery services</b>                                             | <b>\$350</b> copay                                                                | <b>\$350</b> copay                                                                |
| <b>AMBULATORY SURGERY CENTER</b>                                    |                                                                                   |                                                                                   |
| <b>Diagnostic colonoscopy</b>                                       | <b>\$0</b> copay                                                                  | <b>\$0</b> copay                                                                  |
| <b>Surgery services</b>                                             | <b>\$250</b> copay                                                                | <b>\$250</b> copay                                                                |
| <b>DOCTOR VISITS</b>                                                |                                                                                   |                                                                                   |
| <b>Primary care provider (PCP)</b>                                  |                                                                                   |                                                                                   |
| • PCP's office                                                      | <b>\$0</b> copay                                                                  | <b>\$0</b> copay                                                                  |
| • Telehealth                                                        | <b>\$0</b> copay                                                                  | <b>Not Covered</b>                                                                |
| <b>Specialist</b>                                                   |                                                                                   |                                                                                   |
| • Specialist's office                                               | <b>\$45</b> copay                                                                 | <b>\$45</b> copay                                                                 |
| • Telehealth                                                        | <b>\$45</b> copay                                                                 | <b>Not Covered</b>                                                                |

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

**Humana.**



|                                                                                                                                                                                                                                       | IN-NETWORK       | OUT-OF-NETWORK   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------|
| <b>PREVENTIVE CARE</b>                                                                                                                                                                                                                |                  |                  |
| This plan covers all Medicare preventive services including:                                                                                                                                                                          | <b>\$0</b> copay | <b>\$0</b> copay |
| <b>Cancer Screenings</b>                                                                                                                                                                                                              |                  |                  |
| <ul style="list-style-type: none"><li>Breast cancer screening (mammogram)</li><li>Cervical and vaginal cancer screening</li><li>Colorectal cancer screening</li><li>Lung cancer screening</li><li>Prostate cancer screening</li></ul> |                  |                  |
| <b>Cardiovascular (heart) Care</b>                                                                                                                                                                                                    |                  |                  |
| <ul style="list-style-type: none"><li>Abdominal aortic aneurysm screening</li><li>Cardiovascular disease risk reduction visit</li><li>Cardiovascular disease screenings</li></ul>                                                     |                  |                  |
| <b>Diabetes Care</b>                                                                                                                                                                                                                  |                  |                  |
| <ul style="list-style-type: none"><li>Diabetes screenings</li><li>Diabetes self-management training</li><li>Medicare Diabetes Prevention Program (MDPP)</li></ul>                                                                     |                  |                  |
| <b>Dietary Guidance and Support</b>                                                                                                                                                                                                   |                  |                  |
| <ul style="list-style-type: none"><li>Medical nutrition therapy</li><li>Obesity screening and therapy</li></ul>                                                                                                                       |                  |                  |
| <b>Routine Screenings and Immunizations</b>                                                                                                                                                                                           |                  |                  |
| <ul style="list-style-type: none"><li>Annual Wellness Visit (AWV)</li><li>Immunizations</li><li>Routine physical exam</li><li>"Welcome to Medicare" preventive visit</li></ul>                                                        |                  |                  |
| <b>Screenings and Counseling Services</b>                                                                                                                                                                                             |                  |                  |
| <ul style="list-style-type: none"><li>Bone mass measurement</li><li>Depression screening</li></ul>                                                                                                                                    |                  |                  |

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



Medical Benefits (cont.)

IN-NETWORK

OUT-OF-NETWORK

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

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

EMERGENCY CARE

Emergency services at emergency room

\$130 copay

\$130 copay

If you are admitted to the same hospital within 24 hours for the same condition, you pay \$0 for the emergency care you received.

**We cover emergency services worldwide. If you have an emergency outside of the U.S. and its territories, you will be responsible to pay for the rendered service(s) upfront and can request reimbursement.**

When placed in observation, member pays observation cost-share instead of emergency room cost-share.

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





## Medical Benefits (cont.)

|                                                                                                                                                                                                                                                                                                                                                                                                          | IN-NETWORK         | OUT-OF-NETWORK     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|--------------------|
| <b>URGENTLY NEEDED SERVICES</b>                                                                                                                                                                                                                                                                                                                                                                          |                    |                    |
| • <b>Telehealth</b>                                                                                                                                                                                                                                                                                                                                                                                      | <b>\$50</b> copay  | <b>Not Covered</b> |
| • <b>Urgent care center</b>                                                                                                                                                                                                                                                                                                                                                                              | <b>\$50</b> copay  | <b>\$50</b> copay  |
| <p>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical attention. <b>We cover urgently needed services worldwide. If you have an urgently needed service outside of the U.S. and its territories, you will be responsible to pay for the rendered service(s) upfront and can request reimbursement.</b></p> |                    |                    |
| <b>DIAGNOSTIC SERVICES, LABS AND IMAGING</b>                                                                                                                                                                                                                                                                                                                                                             |                    |                    |
| <b>Advanced imaging services (MRI, MRA, PET and CT scans)</b>                                                                                                                                                                                                                                                                                                                                            |                    |                    |
| • Freestanding radiological facility                                                                                                                                                                                                                                                                                                                                                                     | <b>\$200</b> copay | <b>\$200</b> copay |
| • Outpatient hospital                                                                                                                                                                                                                                                                                                                                                                                    | <b>\$335</b> copay | <b>\$335</b> copay |
| • PCP's office                                                                                                                                                                                                                                                                                                                                                                                           | <b>\$200</b> copay | <b>\$200</b> copay |
| • Specialist's office                                                                                                                                                                                                                                                                                                                                                                                    | <b>\$280</b> copay | <b>\$280</b> copay |
| <b>Basic radiological services (X-rays)</b>                                                                                                                                                                                                                                                                                                                                                              |                    |                    |
| • Freestanding radiological facility                                                                                                                                                                                                                                                                                                                                                                     | <b>\$50</b> copay  | <b>\$50</b> copay  |
| • Outpatient hospital                                                                                                                                                                                                                                                                                                                                                                                    | <b>\$130</b> copay | <b>\$130</b> copay |
| • PCP's office                                                                                                                                                                                                                                                                                                                                                                                           | <b>\$0</b> copay   | <b>\$0</b> copay   |
| • Specialist's office                                                                                                                                                                                                                                                                                                                                                                                    | <b>\$45</b> copay  | <b>\$45</b> copay  |
| • Urgent care center                                                                                                                                                                                                                                                                                                                                                                                     | <b>\$50</b> copay  | <b>\$50</b> copay  |
| <b>Diagnostic mammography</b>                                                                                                                                                                                                                                                                                                                                                                            |                    |                    |
| • Freestanding radiological facility                                                                                                                                                                                                                                                                                                                                                                     | <b>\$0</b> copay   | <b>\$0</b> copay   |
| • Specialist's office                                                                                                                                                                                                                                                                                                                                                                                    | <b>\$0</b> copay   | <b>\$0</b> copay   |

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



## Medical Benefits (cont.)

|                                                  | IN-NETWORK             | OUT-OF-NETWORK         |
|--------------------------------------------------|------------------------|------------------------|
| <b>Diagnostic procedures and tests</b>           |                        |                        |
| • Outpatient hospital                            | <b>\$100</b> copay     | <b>\$100</b> copay     |
| • PCP's office                                   | <b>\$0</b> copay       | <b>\$0</b> copay       |
| • Specialist's office                            | <b>\$45</b> copay      | <b>\$45</b> copay      |
| • Urgent care center                             | <b>\$50</b> copay      | <b>\$50</b> copay      |
| <b>Lab services</b>                              |                        |                        |
| • Freestanding laboratory                        | <b>\$0</b> copay       | <b>\$0</b> copay       |
| • Outpatient hospital                            | <b>\$0</b> copay       | <b>\$0</b> copay       |
| • PCP's office                                   | <b>\$0</b> copay       | <b>\$0</b> copay       |
| • Specialist's office                            | <b>\$0</b> copay       | <b>\$0</b> copay       |
| • Urgent care center                             | <b>\$50</b> copay      | <b>\$50</b> copay      |
| <b>Nuclear medicine and services</b>             |                        |                        |
| • Freestanding radiological facility             | <b>\$180</b> copay     | <b>\$180</b> copay     |
| • Outpatient hospital                            | <b>\$780</b> copay     | <b>\$780</b> copay     |
| <b>Sleep study</b>                               |                        |                        |
| • Member's home                                  | <b>\$0</b> copay       | <b>\$0</b> copay       |
| • Outpatient hospital                            | <b>\$100</b> copay     | <b>\$100</b> copay     |
| • Specialist's office                            | <b>\$45</b> copay      | <b>\$45</b> copay      |
| <b>Therapeutic radiology (Radiation therapy)</b> |                        |                        |
| • Freestanding radiological facility             | <b>20%</b> of the cost | <b>20%</b> of the cost |
| • Outpatient hospital                            | <b>20%</b> of the cost | <b>20%</b> of the cost |
| • Specialist's office                            | <b>20%</b> of the cost | <b>20%</b> of the cost |



## HEARING SERVICES

|                                               |                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                |
|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Medicare-covered hearing</b>               | <b>\$45</b> copay                                                                                                                                                                                                                                                                                                     | <b>\$45</b> copay                                                                                                                              |
| <b>Mandatory supplemental hearing benefit</b> | <b>HER959</b> <ul style="list-style-type: none"> <li>• <b>\$0</b> copay for routine hearing exams up to 1 per year.</li> <li>• <b>\$99</b> copay for each Standard level hearing aid up to 1 per ear per year.</li> <li>• <b>\$399</b> copay for each Advanced level hearing aid up to 1 per ear per year.</li> </ul> | Hearing aids must be purchased through TruHearing. Coverage will not be provided for hearing aids purchased from a non-participating provider. |

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

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## Medical Benefits (cont.)

|  | IN-NETWORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | OUT-OF-NETWORK |
|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
|  | <ul style="list-style-type: none"> <li>• <b>\$699</b> copay for each Premium level hearing aid up to 1 per ear per year.</li> </ul> <p>Hearing aid purchase includes:</p> <ul style="list-style-type: none"> <li>• Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase</li> <li>• 60-day trial period</li> <li>• 3-year extended warranty</li> <li>• 80 batteries per aid for non-rechargeable models</li> <li>• Rechargeable style options available for Premium and Advanced aids for an additional <b>\$50</b> per aid</li> </ul> <p><b>You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (TTY: 711).</b></p> |                |



## DENTAL SERVICES

| Medicare-covered dental                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | \$45 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | \$45 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Mandatory supplemental dental benefit</b><br>Limitations and exclusions may apply. Please see your Evidence of Coverage (EOC) for additional details. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. Dental benefits under this plan may not cover all ADA procedure codes. Any services received that are not listed will not be covered by the plan and will be the member's responsibility. The member is responsible for any amount above the annual maximum | <b>DENB26</b> <ul style="list-style-type: none"> <li>• <b>\$0</b> copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.</li> <li>• <b>\$0</b> copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years.</li> <li>• <b>\$0</b> copay for bridge recementation, crown recementation, panoramic film or diagnostic x-rays up to 1 every 5 years.</li> <li>• <b>\$0</b> copay for crown, other restorative services - core buildup and prefabricated post</li> </ul> | <b>DENB26</b> <ul style="list-style-type: none"> <li>• <b>\$0</b> copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.</li> <li>• <b>\$0</b> copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years.</li> <li>• <b>\$0</b> copay for bridge recementation, crown recementation, panoramic film or diagnostic x-rays up to 1 every 5 years.</li> <li>• <b>\$0</b> copay for crown, other restorative services - core buildup and prefabricated post</li> </ul> |

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



## Medical Benefits (cont.)

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | IN-NETWORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | OUT-OF-NETWORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>benefit coverage amount. Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. Information regarding each plan is available at <b>Humana.com/sb</b>.</p> <p>In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule (but any applicable coinsurance payment still applies). Visiting an in-network provider may result in significant savings. The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator for our nationwide network can be found at <b>Humana.com/FindCare</b>.</p> <p>Out-of-network dentists have not agreed to provide services at contracted fees. <b>The out-of-network provider may bill the member for more than what the plan pays, even for services listed with no member cost share. Members are responsible for this difference between Humana's reimbursement and the out-of-network provider's charges. This is known as balance billing.</b> Benefits received out-of-network are subject to any</p> | <p>and core, root canal, root canal retreatment up to 1 per tooth per lifetime.</p> <ul style="list-style-type: none"> <li>• <b>\$0</b> copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.</li> <li>• <b>\$0</b> copay for adjustments to dentures, denture rebase, denture relines, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year.</li> <li>• <b>\$0</b> copay for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.</li> <li>• <b>\$0</b> copay for periodontal maintenance up to 4 per year.</li> <li>• <b>\$0</b> copay for necessary anesthesia with covered service up to as needed with covered codes per year.</li> <li>• <b>\$0</b> copay for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year.</li> <li>• <b>30%</b> of the cost for bridges-pontic, complete dentures, partial dentures up to 1 every 5 years.</li> <li>• <b>30%</b> of the cost for bridges-crown up to 2 every 5 years.</li> <li>• <b>\$3,000</b> combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.</li> </ul> | <p>and core, root canal, root canal retreatment up to 1 per tooth per lifetime.</p> <ul style="list-style-type: none"> <li>• <b>\$0</b> copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.</li> <li>• <b>\$0</b> copay for adjustments to dentures, denture rebase, denture relines, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year.</li> <li>• <b>\$0</b> copay for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.</li> <li>• <b>\$0</b> copay for periodontal maintenance up to 4 per year.</li> <li>• <b>\$0</b> copay for necessary anesthesia with covered service up to as needed with covered codes per year.</li> <li>• <b>\$0</b> copay for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year.</li> <li>• <b>30%</b> of the cost for bridges-pontic, complete dentures, partial dentures up to 1 every 5 years.</li> <li>• <b>30%</b> of the cost for bridges-crown up to 2 every 5 years.</li> <li>• <b>\$3,000</b> combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.</li> <li>• Benefits received out-of-network are subject to any in-network benefit</li> </ul> |

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

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## Medical Benefits (cont.)

| IN-NETWORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | OUT-OF-NETWORK                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| <p>in-network benefit maximums, limitations and/or exclusions. Members may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Please see above for provider locator instructions. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement. The coinsurance level will apply to the average negotiated in-network fee schedule (INFS) in your area. See Chapter 2 Payment Requests Contact Information in your Evidence of Coverage or visit <b>Humana.com</b> for information on requesting reimbursement.</p> | <p>maximums, limitations, and/or exclusions.</p> |



### VISION SERVICES

|                                                                                                                                                                                                   |                                                                                                                                                                                                                  |                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Eyewear (post cataract surgery)</b>                                                                                                                                                            | <b>\$0</b> copay                                                                                                                                                                                                 | <b>\$0</b> copay                                                                                                                                                                                                 |
| <b>Medicare-covered diabetic eye exam</b>                                                                                                                                                         | <b>\$0</b> copay                                                                                                                                                                                                 | <b>\$0</b> copay                                                                                                                                                                                                 |
| <b>Medicare-covered vision services</b><br>The provider locator for Medicare-covered vision can be found at <b>Humana.com/FindCare</b> .                                                          | <b>\$45</b> copay                                                                                                                                                                                                | <b>\$45</b> copay                                                                                                                                                                                                |
| <b>Mandatory supplemental vision benefit</b><br>Please inform the network provider that you are part of the Humana Medicare Insight Network. NOTE: The network of providers for your supplemental | <b>VIS699</b> <ul style="list-style-type: none"> <li>• <b>\$0</b> copay for routine exam up to 1 per year.</li> <li>• <b>\$40</b> combined maximum benefit coverage amount per year for routine exam.</li> </ul> | <b>VIS699</b> <ul style="list-style-type: none"> <li>• <b>\$0</b> copay for routine exam up to 1 per year.</li> <li>• <b>\$40</b> combined maximum benefit coverage amount per year for routine exam.</li> </ul> |

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



## Medical Benefits (cont.)

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | IN-NETWORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | OUT-OF-NETWORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>vision benefits through Humana Medicare Insight Network may be different than the network of providers for the Medicare-covered vision benefits. The provider locator can be found at <b>Humana.com/FindCare</b>. Benefit allowance is applied toward the retail price. Member is responsible for any costs above the plan approved amount. Lost or broken materials are not covered. This benefit is limited to a one-time use per year. Any remaining benefit dollars do not "roll over" to a future purchase. Eyeglass lens options may be available with the maximum benefit coverage amount up to one pair per year. Benefits are offered on a calendar basis. Any amount unused by the end of the year will expire. Copayments, coinsurances, and deductibles paid for supplemental benefits do not count toward your maximum out-of-pocket amount.</p> | <ul style="list-style-type: none"> <li>• <b>\$200</b> maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.</li> <li>• OR</li> <li>• <b>\$300</b> maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.</li> <li>• Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year.</li> <li>• Maximum benefit coverage amount is limited to one time use per year.</li> <li>• Maximum benefit coverage amounts cannot be combined.</li> </ul> <p>PLUS providers are part of the Humana Medicare Insight Network and will display the PLUS Provider indicator in the provider locator search results found at <b>Humana.com/FindCare</b>.</p> | <ul style="list-style-type: none"> <li>• <b>\$200</b> maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.</li> <li>• Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year.</li> <li>• Maximum benefit coverage amount is limited to one time use per year.</li> <li>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.</li> <li>• Maximum benefit coverage amounts cannot be combined.</li> </ul> |

### MENTAL HEALTH SERVICES

#### Inpatient

This plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital

**\$350** copay per day for days 1-6  
**\$0** copay per day for days 7-90

**\$350** copay per day for days 1-6  
**\$0** copay per day for days 7-90

#### Mental health therapy visits

- Outpatient hospital **\$35** copay
- Specialist's office **\$35** copay
- Telehealth **\$35** copay

**\$35** copay  
**\$35** copay  
**Not Covered**

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

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## Medical Benefits (cont.)

|                                                                                                                         | IN-NETWORK                                                                            | OUT-OF-NETWORK                                                                        |
|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| <b>Outpatient substance abuse services</b>                                                                              |                                                                                       |                                                                                       |
| • Outpatient hospital                                                                                                   | <b>\$35</b> copay                                                                     | <b>\$35</b> copay                                                                     |
| • Specialist's office                                                                                                   | <b>\$35</b> copay                                                                     | <b>\$35</b> copay                                                                     |
| • Telehealth                                                                                                            | <b>\$35</b> copay                                                                     | <b>Not Covered</b>                                                                    |
| <b>SKILLED NURSING FACILITY (SNF)</b>                                                                                   |                                                                                       |                                                                                       |
| This plan covers up to 100 days in a SNF                                                                                | <b>\$10</b> copay per day for days 1-20<br><b>\$218</b> copay per day for days 21-100 | <b>\$10</b> copay per day for days 1-20<br><b>\$218</b> copay per day for days 21-100 |
| <b>AMBULANCE</b>                                                                                                        |                                                                                       |                                                                                       |
|                                                                                                                         | <b>\$335</b> copay per date of service                                                | <b>\$335</b> copay per date of service                                                |
| <b>TRANSPORTATION</b>                                                                                                   |                                                                                       |                                                                                       |
|                                                                                                                         | Not Covered                                                                           |                                                                                       |
| <b>MEDICARE PART B DRUGS</b>                                                                                            |                                                                                       |                                                                                       |
| Some rebatable Part B drugs may be subject to a lower coinsurance.                                                      |                                                                                       |                                                                                       |
| <b>Allergy shots and serum</b>                                                                                          |                                                                                       |                                                                                       |
| • PCP's office                                                                                                          | <b>\$0</b> copay                                                                      | <b>\$0</b> copay                                                                      |
| • Specialist's office                                                                                                   | <b>\$0</b> copay                                                                      | <b>\$0</b> copay                                                                      |
| <b>Chemotherapy drugs</b>                                                                                               |                                                                                       |                                                                                       |
| • Outpatient hospital                                                                                                   | <b>20%</b> of the cost                                                                | <b>20%</b> of the cost                                                                |
| • Specialist's office                                                                                                   | <b>20%</b> of the cost                                                                | <b>20%</b> of the cost                                                                |
| <b>Other Part B drugs</b>                                                                                               |                                                                                       |                                                                                       |
| • Outpatient hospital                                                                                                   | <b>20%</b> of the cost                                                                | <b>20%</b> of the cost                                                                |
| • PCP's office                                                                                                          | <b>20%</b> of the cost                                                                | <b>20%</b> of the cost                                                                |
| • Pharmacy                                                                                                              | <b>20%</b> of the cost                                                                | <b>20%</b> of the cost                                                                |
| • Specialist's office                                                                                                   | <b>20%</b> of the cost                                                                | <b>20%</b> of the cost                                                                |
| <b>Part B Insulin</b>                                                                                                   |                                                                                       |                                                                                       |
| • Outpatient hospital                                                                                                   | <b>20%</b> of the cost                                                                | <b>20%</b> of the cost                                                                |
| • PCP's office                                                                                                          | <b>20%</b> of the cost                                                                | <b>20%</b> of the cost                                                                |
| • Pharmacy                                                                                                              | <b>20%</b> of the cost                                                                | <b>20%</b> of the cost                                                                |
| • Specialist's office                                                                                                   | <b>20%</b> of the cost                                                                | <b>20%</b> of the cost                                                                |
| You won't pay more than <b>\$35</b> for a one-month (up to 30-day) supply of each insulin product covered by this plan. |                                                                                       |                                                                                       |

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



## Prescription Drug Benefits

### PLAN HIGHLIGHTS

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

### DEDUCTIBLE

**\$0** deductible for Tier 1, Tier 2 and Tier 3. This plan has a **\$300** deductible for Tier 4 and Tier 5 drugs. You pay the full cost of these drugs until you reach **\$300**. Then, you only pay your cost-share.

### INITIAL COVERAGE

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

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## Pharmacy Cost-Sharing

|                                   | <b>Retail Cost-Sharing</b><br>Includes all in-network<br>retail pharmacies |                 | <b>Standard Mail-Order<br/>Cost-Sharing</b> |                 | <b>Preferred Mail-Order<br/>Cost-Sharing</b><br>CenterWell Pharmacy™ |                 |
|-----------------------------------|----------------------------------------------------------------------------|-----------------|---------------------------------------------|-----------------|----------------------------------------------------------------------|-----------------|
| <b>Day supply</b>                 | <b>30-day</b>                                                              | <b>100-day*</b> | <b>30-day</b>                               | <b>100-day*</b> | <b>30-day</b>                                                        | <b>100-day*</b> |
| <b>Tier 1:</b> Preferred Generic  | \$0                                                                        | \$0             | \$10                                        | \$30            | \$0                                                                  | \$0             |
| <b>Tier 2:</b> Generic            | \$10                                                                       | \$30            | \$20                                        | \$60            | \$10                                                                 | \$0             |
| <b>Tier 3:</b> Preferred Brand    | \$47                                                                       | \$141           | \$47                                        | \$141           | \$47                                                                 | \$131           |
| <b>Tier 4:</b> Non-Preferred Drug | 50%                                                                        | 50%             | 50%                                         | 50%             | 50%                                                                  | 50%             |
| <b>Tier 5:</b> Specialty Tier     | 29%                                                                        | N/A             | 29%                                         | N/A             | 29%                                                                  | N/A             |

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

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

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

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

## Insulin Cost-Sharing

|                                   | <b>Retail Cost-Sharing</b><br>Includes all in-network<br>retail pharmacies |                 | <b>Standard Mail-Order<br/>Cost-Sharing</b> |                 | <b>Preferred Mail-Order<br/>Cost-Sharing</b><br>CenterWell Pharmacy™ |                 |
|-----------------------------------|----------------------------------------------------------------------------|-----------------|---------------------------------------------|-----------------|----------------------------------------------------------------------|-----------------|
| <b>Day supply</b>                 | <b>30-day</b>                                                              | <b>100-day*</b> | <b>30-day</b>                               | <b>100-day*</b> | <b>30-day</b>                                                        | <b>100-day*</b> |
| <b>Tier 1:</b> Preferred Generic  | \$0                                                                        | \$0             | 25% up to \$10                              | 25% up to \$30  | \$0                                                                  | \$0             |
| <b>Tier 2:</b> Generic            | 25% up to \$10                                                             | 25% up to \$30  | 25% up to \$20                              | 25% up to \$60  | 25% up to \$10                                                       | \$0             |
| <b>Tier 3:</b> Preferred Brand    | 25% up to \$35                                                             | 25% up to \$105 | 25% up to \$35                              | 25% up to \$105 | 25% up to \$35                                                       | 25% up to \$95  |
| <b>Tier 4:</b> Non-Preferred Drug | 25% up to \$35                                                             | 25% up to \$105 | 25% up to \$35                              | 25% up to \$105 | 25% up to \$35                                                       | 25% up to \$105 |
| <b>Tier 5:</b> Specialty Tier     | 25% up to \$35                                                             | N/A             | 25% up to \$35                              | N/A             | 25% up to \$35                                                       | N/A             |

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

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

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

### CATASTROPHIC COVERAGE

After your total out-of-pocket costs reach **\$2,100** you pay **\$0** for plan-covered Part D drugs.

### EXTRA HELP

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

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

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

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

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

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



## Additional Benefits

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



## Additional Benefits (cont.)

### Physical therapy

|                                           |                   |                   |
|-------------------------------------------|-------------------|-------------------|
| • Comprehensive outpatient rehab facility | <b>\$10</b> copay | <b>\$10</b> copay |
| • Outpatient hospital                     | <b>\$40</b> copay | <b>\$40</b> copay |
| • Specialist's office                     | <b>\$10</b> copay | <b>\$10</b> copay |

### Pulmonary rehabilitation

|                       |                   |                   |
|-----------------------|-------------------|-------------------|
| • Outpatient hospital | <b>\$15</b> copay | <b>\$15</b> copay |
| • Specialist's office | <b>\$15</b> copay | <b>\$15</b> copay |

### Speech therapy

|                                           |                   |                   |
|-------------------------------------------|-------------------|-------------------|
| • Comprehensive outpatient rehab facility | <b>\$10</b> copay | <b>\$10</b> copay |
| • Outpatient hospital                     | <b>\$40</b> copay | <b>\$40</b> copay |
| • Specialist's office                     | <b>\$10</b> copay | <b>\$10</b> copay |

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

|                       |                   |                   |
|-----------------------|-------------------|-------------------|
| • Outpatient hospital | <b>\$10</b> copay | <b>\$10</b> copay |
| • Specialist's office | <b>\$10</b> copay | <b>\$10</b> copay |



## More benefits with **this plan**

Enjoy some of these extra benefits included in this plan.

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

### **Over-the-Counter (OTC) Allowance**

**\$50** quarterly allowance on a prepaid spending card to buy approved over-the-counter health and wellness products at participating retail locations or through the plan's approved OTC mail order vendor.

Unused amount expires at the end of the quarter.

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

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

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

### **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.

### **Routine foot care**

- In-network: **\$35** copay for routine podiatry visits up to 6 visit(s) per year.
- Out-of-network: **\$35** copay for routine podiatry visits up to 6 visit(s) per year.

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

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

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

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

Limited to 4 times per year.

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

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

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

**SilverSneakers® fitness program**

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

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

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



## Find out **more**

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



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

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

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

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

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

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

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

## More information is just a click away.

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

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

## Activate your secure MyHumana account.

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

### Already have an account?

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

### Don't have an account yet?

Create one using the same link above in just minutes.

## Receiving information about other insurance products

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

## Notice of Non-Discrimination

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

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

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

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

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

This notice is available at **[www.humana.com/legal/non-discrimination-disclosure](http://www.humana.com/legal/non-discrimination-disclosure)**.

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# Notice of Availability - Auxiliary Aids and Services Notice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ភាសាខ្មែរ [Khmer]: សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជំនួយផ្សេងៗដល់អ្នកមានការពិការភាព។ ទូរសព្ទទៅលេខ **877-320-1235 (TTY: 711)**។

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Bàsàwà [Bassa]: Wuḍu-xwíníín-mú-zà-zà kùà, Hwòdǒ-fańa-nyo, kè nyo-boŭn-po-kà bě bě nyuεε se wíqí pée-pée dǒ ko. **877-320-1235 (TTY: 711)** dá.

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

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

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

# Notes

H5216011000

**Humana Inc.**

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

Important information about this plan

**Humana.com**



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

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



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



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



**Created and regularly updated by doctors and pharmacists**



**Available in multiple languages**



View this plan's Prescription Drug Guide at **[huma.na/20260013PDG](https://huma.na/20260013PDG)** or scan the QR code with your smartphone or tablet's camera.



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



Discover our network of retail and mail-order pharmacies at **[Humana.com/Pharmacy](https://Humana.com/Pharmacy)**. CenterWell Pharmacy® mail delivery is one of many options in your pharmacy network. Check this plan's Evidence of Coverage for more information on how to fill your prescriptions.

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# Care and communication on your terms

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

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

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



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

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



## **How to get started\***

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

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

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

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

**Humana.**

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# Consent for release of protected health information

**Member information** (person whose information will be released):  
Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  

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<sup>†</sup> information (PHI) described below:** (Please check only **one** box)  
  
☐ Full Disclosure: Any protected health information Humana and its affiliates maintains, including mental health, HIV, health status or substance use or disorder records. This also includes sharing information on mail-order pharmacy, wellness products, and health programs with the person being authorized.  
  
☐ Limited Disclosure: You specify what PHI to share, e.g., condition or treatment information, a specific date range, or product type. Unless you limit by product type, information will apply to all products and services. \_\_\_\_\_  
  
\_\_\_\_\_  
If Limited Disclosure was selected please indicate which product(s) apply:  
  
☐ **Medical and/or prescription coverage** ☐ **Vision** ☐ **Dental** ☐ **Centerwell Pharmacy™ (mail delivery)** ☐ **Go365®**

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

First Middle Last Required Field Month Day Year

  
Or if organization: \_\_\_\_\_  

Name

  
Address: \_\_\_\_\_  

Street City State ZIP

  
Email: \_\_\_\_\_  
Phone #: \_\_\_\_\_ ☐ Home ☐ Cell\*  
Relationship: ☐ Spouse ☐ Sibling ☐ Parent ☐ Child ☐ Agent/Broker ☐ Friend ☐ Organization

- I understand:
- I am not required to fill out this consent and Humana cannot base decisions regarding treatment, payment, enrollment or eligibility for benefits on whether I submit it.
  - Disclosures may include information from past, present, and/or future treating providers.
  - This consent is valid until I cancel my Humana membership. For customers in the following states—CA, CT, GA, IL, MA, MD, MT, NC, NJ, NV, OH, OR, VA—consents will expire in compliance with applicable state laws.<sup>‡</sup>
  - If I cancel consent, it will not apply to any information previously released with this authorization. Once information is shared, Humana cannot prevent the person or organization who has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.
  - **THIS IS NOT A CONSENT for legally appointed POWER OF ATTORNEY.** By submitting this form, I am aware the person signing this consent is not permitted to request preauthorization's for medical or prescription coverage. Additionally, they cannot disenroll me, submit new enrollments, file a grievance, or request an appeal.



Member or Legal Representative signature \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ ☐

Member ☐ Legal Representative

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

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

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

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

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

‡ Expires in 12 months: CA, CT, GA, IL, MA, MD, NC, NJ, NV, OH, OR

Expires in 24 months: MT, VA

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

For Humana Use Only

**Humana**®

# Scope of Appointment form

It's important for you to understand the type of health product(s) that you can choose to discuss before your appointment with a licensed Humana sales agent. The Centers for Medicare & Medicaid Services (CMS) requires sales agents to document the scope of any personal marketing appointment 48 hours prior to the scheduled appointment, except for Scope of Appointment forms that are completed during the last four days of a valid election period for the beneficiary or for unscheduled, in-person meetings (walk-ins) or inbound calls initiated by the beneficiary. All information provided on this form is confidential, and a separate form should be completed by each beneficiary who wishes to discuss plan options or by their legally authorized representative. We look forward to speaking with you.

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

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

## Medicare Advantage plans (Part C)

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

### Health maintenance organization (HMO) plan

This type of MA plan typically requires you to see only in-network providers and you may need a referral from a primary care physician to see a specialist.

### Preferred provider organization (PPO) plan

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

### Private fee-for-service (PFFS) plan

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

### Special Needs Plan (SNP)

This type of MA plan has a benefits package designed for people with special healthcare needs. Examples of groups served include people who have both Medicare and Medicaid, reside in nursing homes, and/or have been diagnosed with an eligible chronic condition.

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

### Medicare prescription drug plans (PDP)

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

## Other products

### Medicare Supplement plans

Medicare Supplement plans are standardized plans that can be bought with varying coverage options to help supplement your Original Medicare plan. While an MA plan takes the place of Original Medicare, a Medicare Supplement plan is simply added on to Original Medicare. Medicare Supplement plans have no provider networks and help pay some of the costs that Original Medicare does not pay. Medicare Supplement plans cannot be paired or used with an MA plan.

### Dental plans

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

### Vision plans

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

### Hospital Indemnity plans

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

**Humana.**

# Scope of Appointment

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

☐ Medicare Advantage plans (Part C)

☐ Dental plans

☐ Stand-alone prescription drug plans (Part D)

☐ Vision plans

☐ Medicare Supplement plans

☐ Hospital Indemnity plans

Name \_\_\_\_\_

Phone \_\_\_\_\_

Address (Street, City, State ZIP code) \_\_\_\_\_

Relationship to the beneficiary \_\_\_\_\_

\_\_\_\_\_

Medicare ID number (optional) \_\_\_\_\_

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

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

Beneficiary or legally authorized representative signature and signature date:

Signature \_\_\_\_\_

Signature date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Agent name \_\_\_\_\_

Agent phone \_\_\_\_\_

Agent SAN \_\_\_\_\_

Date and time of form completion:

\_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_:\_\_\_\_ [ ] a.m. [ ] p.m.

**Agent please mail this form to:**

MarketPoint

P.O. Box 14637

Lexington, KY 40512-4637

Or fax to: **877-889-9936**

Initial method of contact: \_\_\_\_\_

Date and time of scheduled appointment:

\_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_:\_\_\_\_ [ ] a.m. [ ] p.m.

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

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

[ ] Walk-in meeting initiated by beneficiary

[ ] Inbound call initiated by beneficiary

Agent signature \_\_\_\_\_ Agent signature date \_\_\_\_/\_\_\_\_/\_\_\_\_

Plan(s) the agent represented \_\_\_\_\_

Application number or recording ID \_\_\_\_\_

Date appointment completed \_\_\_\_/\_\_\_\_/\_\_\_\_

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



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



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



**Scan the QR code** with your phone or tablet's camera or go to **<https://huma.na/26appGNHHUTSEN>** to view and print the enrollment form.



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

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

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

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

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

\* Plans are not available in all states. Plan benefits may vary by state. Refer to the plan documents for complete details of coverage. Dental and vision plans, excluding Dental Savings Plus, may have a minimum one-year initial contract period. Payment may include an administration fee. Association membership and fees may be required on some plans in some states. A one-time, non-refundable enrollment fee may apply (the fee is non-refundable as allowed by state requirements). Applicable fees are disclosed at time of enrollment. These are not Medicare plans. For Arizona: This is a solicitation of insurance. A licensed insurance agent/producer may contact you. For Texas: A person should not send money to the issuer in response to the advertisement and a person cannot obtain coverage under the health benefit plan without completing application for coverage.

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

# Receipt of Enrollment form

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

|                                         |                                                 |
|-----------------------------------------|-------------------------------------------------|
| Member name                             | Humana licensed sales agent name / phone number |
| Application ID number                   | Plan name                                       |
| Plan type                               | Proposed effective date                         |
| Primary care provider (PCP)             | PCP phone number (if applicable)                |
| Plan premium _____ Copayment: PCP _____ | Specialist _____ ER _____                       |

☐ I have read and reviewed the Summary of Benefits.

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

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

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

|                                       |                                  |
|---------------------------------------|----------------------------------|
| RX plan – _____                       | – _____                          |
| Processor control number (PCN)        | Bank identification number (BIN) |
| – _____                               | – _____                          |
| Contract – Plan benefit package (PBP) | Segment                          |
| Member signature _____                | Agent signature _____            |
| Date _____                            | Date _____                       |



## Humana Customer Care

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

**Oct. 1 – Mar. 31**

Daily

8 a.m. – 8 p.m.

**Apr. 1 – Sept. 30**

Monday – Friday

8 a.m. – 8 p.m.

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

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

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

## IMPORTANT INFORMATION:

### 2026 Medicare Star Ratings

Official U.S.  
Government  
Medicare  
Information



#### Humana - H5216

For 2026, Humana - H5216 received the following Star Ratings from Medicare:

**Overall Star Rating:** ★★★★★

**Health Services Rating:** ★★★★★

**Drug Services Rating:** ★★★★★

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

#### Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

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

Star Ratings are based on factors that include:

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

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

#### Get More Information on Star Ratings Online

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

#### Questions about this plan?

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

The number of stars show how well a plan performs.

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



# Important resources guide

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

## **MyHumana**

Create a secure online account.

**MyHumana.com**

## **Find Care**

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

**FindCare.Humana.com**

## **Home healthcare services**

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

**Humana.com/Home-Care**

## **Virtual visits**

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

**Humana.com/VirtualVisits**

## **Supplemental Dental Benefits**

If the plan you choose has embedded dental benefits, view the DENxxx benefit description to see what's covered.<sup>†††</sup>

**Humana.com/SB**

## **Humana Community Navigator®**

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

**Humana.FindHelp.com**

## **Go365 by Humana®**

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

**Go365.com**

## **Dental, vision or hearing**

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

**Humana.com/Dental**



## **Humana Customer Care**

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

Oct. 1 – Mar. 31

Daily, 8 a.m. – 8 p.m.

Apr. 1 – Sept. 30

Monday – Friday, 8 a.m. – 8 p.m.

Not all benefits and resources listed are available on all plans or in all areas. Consult your Evidence of Coverage or ask your licensed sales agent to find out what benefits are included in this plan. Please refer to the Summary of Benefits to learn if your plan includes Go365 by Humana. Go365 by Humana is offered on most plans at no extra charge.

<sup>†††</sup> Prospects without an ID card can locate the DENxxx associated with their plan in the Summary of Benefits and in the Evidence of Coverage.

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

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

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

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

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

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