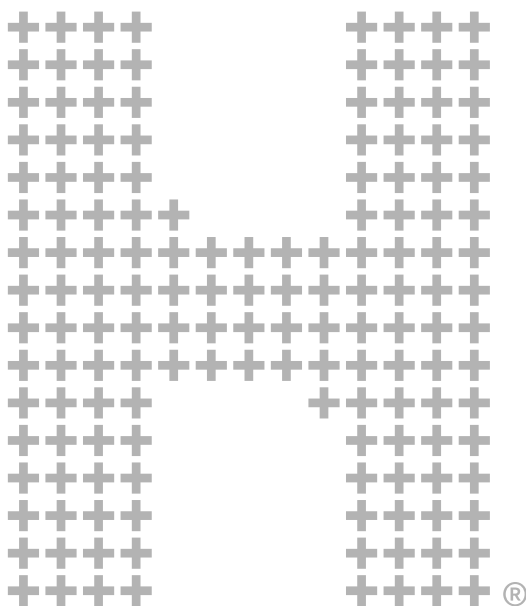


PPO

HumanaChoice SNP-DE
H5216-388-000
Select Counties in MI
H5216388000DSNPEN26PODPPPOF

MI: Alcona, Allegan, Alpena, Antrim, Arenac, Bay, Benzie, Charlevoix, Cheboygan, Clare, Clinton, Crawford, Eaton, Emmet, Gladwin, Grand Traverse, Gratiot, Hillsdale, Huron, Ionia, Iosco, Isabella, Jackson, Kalkaska, Kent, Lake, Leelanau, Lenawee, Manistee, Mason, Mecosta, Midland, Missaukee, Monroe, Montcalm, Montmorency, Muskegon, Newaygo, Oceana, Ogemaw, Osceola, Oscoda, Otsego, Ottawa, Presque Isle, Roscommon, Saginaw, Shiawassee, Wexford



Enrollment book

2026 D-SNP

Dual Eligible Special Needs Plan

The care you deserve
so you can focus on your health

Humana®

Humana®

2026 D-SNP

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 on your journey to help you feel your best. Your Dual Eligible Special Needs Plan (D-SNP) 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



May include a **monthly allowance** to help pay for covered over-the-counter (OTC) items and, if you qualify, for eligible groceries, rent, utilities and more.^{***}



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



May include hundreds of prescriptions with a **\$0 copay**—so you'll pay nothing for them all year long.[‡]



Care Manager Support to work with you right from the start to help you manage the needs of your chronic condition

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](https://www.humana.com/findhelp)

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

H5216-388-000

- ☒ **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

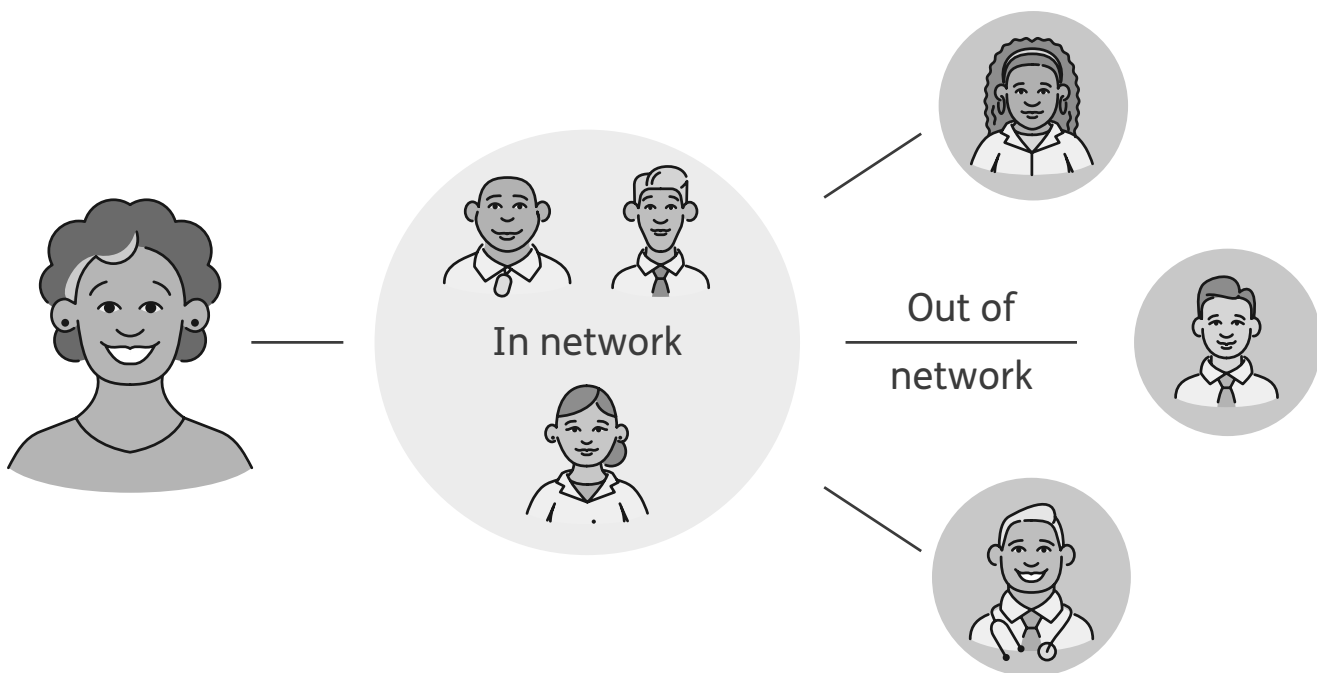
Here's how a PPO Medicare Advantage plan would work. (See all your Medicare options on the following page.)

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.



Medicaid may offer benefits that Medicare doesn't normally cover, like nursing home care and personal care services, to those who qualify for Medicaid.

Step

2

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



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

A Dual Eligible Special Needs Plan, also called a D-SNP, coordinates the benefits of Medicaid and Medicare Parts A and B.

Medicare Advantage enrollees can also purchase individual dental and vision plans, or combined dental, vision and hearing plans for added coverage.*

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

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

* 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.

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Extra Help



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

→ To learn more or apply, contact:

Medicare

1-800-MEDICARE (1-800-633-4227)

(TTY: 1-877-486-2048)

24 hours a day, 7 days a week

www.medicare.gov

The Social Security Administration

800-772-1213

(TTY: 800-325-0778)

Monday – Friday, 8 a.m. – 7 p.m.,

Local time

www.ssa.gov

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, view your Humana member ID card, 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)
- Helpful resources to support your care—and more



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

Humana Spending Account Card

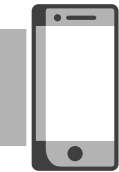
The **Humana Spending Account Card** lets you access the benefit allowance that comes with your plan. Your plan may include a monthly allowance to help pay for covered over-the-counter (OTC) items like vitamins, pain relievers and first aid supplies.

Plus, you may qualify to also use this money for eligible groceries, utilities, rent, and more if you have been diagnosed with certain chronic conditions and meet additional criteria.* Whatever you don't spend carries over each month. To see your plan's available benefits, allowances, allowance amounts and how often they're loaded to your card, review your plan's Evidence of Coverage.



Humana Healthy Options Allowance®	
Everyone who enrolls	Qualifying members*
Use your allowance at participating network retailers, including CenterWell Pharmacy®, on eligible over-the-counter items† in categories including: • Cold, flu and allergy • Dental and denture care • First aid and medical supplies • Incontinence supplies	Qualifying members can choose to use the allowance toward eligible items and services, including: • Over-the-counter (OTC) only products • Home & personal supplies • Groceries • Rent & utilities

If you're diagnosed with qualifying chronic conditions, you can use the Healthy Options allowance to help pay for OTC items plus other eligible items like groceries, rent, utilities, and more.



Call a licensed Humana sales agent to learn more.



* Healthy Options Allowance is a special program for members with specific health conditions. Qualifying conditions include diabetes mellitus, cardiovascular disorders, chronic and disabling mental health conditions, chronic lung disorders, and chronic heart failure, among others. Other requirements apply and some plans require two or more conditions. See the plan's Evidence of Coverage for details. If you use this program for rent or utilities, Housing and Urban Development (HUD) requires it to be reported as income if you seek assistance. Contact your local HUD office if you have questions.

† Learn more about eligible retail products at **[Humana.com/Medicare/Medicare-Programs/Healthy-Options-Allowance](https://www.humana.com/Medicare/Medicare-Programs/Healthy-Options-Allowance)**.

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

Humana is a Medicare Advantage HMO, 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.

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.

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

Summary of Benefits

HumanaChoice SNP-DE H5216-388 (PPO D-SNP)

Michigan

Michigan (Non-Detroit)

Our service area includes the following county/counties in Michigan: Alcona, Allegan, Alpena, Antrim, Arenac, Bay, Benzie, Charlevoix, Cheboygan, Clare, Clinton, Crawford, Eaton, Emmet, Gladwin, Grand Traverse, Gratiot, Hillsdale, Huron, Ionia, Iosco, Isabella, Jackson, Kalkaska, Kent, Lake, Leelanau, Lenawee, Manistee, Mason, Mecosta, Midland, Missaukee, Monroe, Montcalm, Montmorency, Muskegon, Newaygo, Oceana, Ogemaw, Osceola, Oscoda, Otsego, Ottawa, Presque Isle, Roscommon, Saginaw, Shiawassee, 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. The Part A/Part B premiums may be paid for by Michigan Department of Health & Human Services (Medicaid).
- ☐ 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.
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. This plan may enroll FBDE, QMB+, SLMB+.



Let's talk about HumanaChoice SNP-DE H5216-388 (PPO D-SNP)

H5216388000

Find out more about the HumanaChoice SNP-DE H5216-388 (PPO D-SNP) plan – including the health and drug services it covers – in this easy-to-use booklet.

HumanaChoice SNP-DE H5216-388 (PPO D-SNP) is a Dual Eligible Special Needs plan with a Medicare contract and a contract with Michigan Department of Health & Human Services (Medicaid) program. Enrollment in this Humana plan depends on contract renewal.

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

As a member, it's a good idea to select a doctor as your Primary Care Provider(PCP). HumanaChoice SNP-DE H5216-388 (PPO D-SNP) has a network of doctors, hospitals, pharmacies and other providers.

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

To be eligible

If you receive both Medicare and Medicaid benefits, this means you are dual eligible. To enroll in HumanaChoice SNP-DE H5216-388 (PPO D-SNP), a Dual Eligible Special Needs Plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B, live in our service area and also receive certain levels of assistance from Michigan Department of Health & Human Services (Medicaid).

HumanaChoice SNP-DE H5216-388 (PPO D-SNP) may enroll FBDE, QMB+, SLMB+.

Full Benefit Dual Eligible (FBDE): May help pay Medicare Part A and/or Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

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

Specified Low-Income Medicare Beneficiary Plus (SLMB+): Helps pay Part B premiums and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

Plan name

HumanaChoice SNP-DE H5216-388 (PPO D-SNP)

More about HumanaChoice SNP-DE H5216-388 (PPO D-SNP)

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

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

How to reach us

If you have questions about your benefits or your level of eligibility for assistance from Medicaid, you should contact Humana's Customer Care department or Michigan Department of Health & Human Services (Medicaid) for further details.

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**

Medicaid benefits last validated on 07/01/2025 and are subject to change. For the most current Michigan Medicaid coverage information, please visit Michigan Department of Health & Human Services (Medicaid) website at **<https://www.michigan.gov/mdhhs>** or call the Medicaid Hotline at 800-642-3195 (toll free) 711 (TTY).



A healthy partnership

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



Monthly Premium, Deductible and Limits

Monthly plan premium	\$0 You must keep paying your Medicare Part B premium. Your Part A and/or Part B premium may be paid on your behalf by Michigan Department of Health & Human Services (Medicaid) Program.
Medical deductible * You pay the same amount as you would with Original Medicare.	\$0 or \$283* combined in-network and out-of-network deductible for Part B services, depending on your level of Medicaid eligibility.
Pharmacy (Part D) deductible	If you receive Extra Help, this plan has a \$0 deductible. If you do not receive Extra Help, your plan has a \$615 deductible for Tier 3, Tier 4 and Tier 5 drugs. Refer to the Prescription Drug Benefits section below.
Medical Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for covered medical services for the year	\$9,250 in-network \$13,900 combined in- and out-of-network If you are eligible for Medicare cost-sharing assistance under Michigan Department of Health & Human Services (Medicaid) you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.



Medical Benefits

Note: Cost sharing is based on your level of Medicaid eligibility. For this plan, the following Medicaid levels are cost-share protected: FBDE, QMB+ and SLMB+.

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
INPATIENT HOSPITAL COVERAGE		
This plan covers an unlimited number of days for an inpatient stay.	\$0 copay	\$0 or \$2,230 copay per admit
OUTPATIENT HOSPITAL COVERAGE		
Diagnostic colonoscopy	\$0 copay	\$0 or 20% of the cost
Diagnostic mammography	\$0 copay	\$0 or 20% of the cost
Surgery services	\$0 copay	\$0 or 20% of the cost
AMBULATORY SURGERY CENTER		
Diagnostic colonoscopy	\$0 copay	\$0 or 20% of the cost
Surgery services	\$0 copay	\$0 or 20% of the cost

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



Medical Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
DOCTOR VISITS		
Primary care provider (PCP)		
• PCP's office	\$0 copay	\$0 or 20% of the cost
• Telehealth	\$0 copay	Not Covered
Specialist		
• Specialist's office	\$0 copay	\$0 or 20% of the cost
• Telehealth	\$0 copay	Not Covered
PREVENTIVE CARE		
This plan covers all Medicare preventive services including:	\$0 copay	\$0 copay
Cancer Screenings		
• Breast cancer screening (mammogram)		
• Cervical and vaginal cancer screening		
• Colorectal cancer screening		
• Lung cancer screening		
• Prostate cancer screening		
Cardiovascular (heart) Care		
• Abdominal aortic aneurysm screening		
• Cardiovascular disease risk reduction visit		
• Cardiovascular disease screenings		
Diabetes Care		
• Diabetes screenings		
• Diabetes self-management training		
• Medicare Diabetes Prevention Program (MDPP)		
Dietary Guidance and Support		
• Medical nutrition therapy		
• Obesity screening and therapy		

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.



Medical Benefits (cont.)

IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN

OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN

Routine Screenings and Immunizations

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

Screenings and Counseling Services

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

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

EMERGENCY CARE

Emergency room

\$0 copay

\$0 or \$115 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.

*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.)

H5216388000

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
URGENTLY NEEDED SERVICES		
• Telehealth • Urgent care center Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. We cover urgently needed services worldwide. If you have an urgently needed service outside of the U.S. and its territories, you will be responsible to pay for the rendered service(s) upfront and can request reimbursement.	\$0 copay \$0 copay	Not Covered \$0 or 20% of the cost
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Advanced imaging services (MRI, MRA, PET and CT scans)		
• Freestanding radiological facility • Outpatient hospital • PCP's office • Specialist's office	\$0 copay \$0 copay \$0 copay \$0 copay	\$0 or \$200 copay \$0 or \$335 copay \$0 or \$200 copay \$0 or \$280 copay
Basic radiological services (X-rays)		
• Freestanding radiological facility • Outpatient hospital • PCP's office • Specialist's office • Urgent care center	\$0 copay \$0 copay \$0 copay \$0 copay \$0 copay	\$0 or \$50 copay \$0 or 20% of the cost \$0 or 20% of the cost \$0 or 20% of the cost \$0 or 20% of the cost
Diagnostic mammography		
• Freestanding radiological facility • Specialist's office	\$0 copay \$0 copay	\$0 or 20% of the cost \$0 or 20% of the cost

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

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Medical Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
Diagnostic procedures and tests		
• Outpatient hospital	\$0 copay	\$0 or 20% of the cost
• PCP's office	\$0 copay	\$0 or 20% of the cost
• Specialist's office	\$0 copay	\$0 or 20% of the cost
• Urgent care center	\$0 copay	\$0 or 20% of the cost
Lab services		
• Freestanding laboratory	\$0 copay	\$0 or \$30 copay
• Outpatient hospital	\$0 copay	\$0 or 20% of the cost
• PCP's office	\$0 copay	\$0 copay
• Specialist's office	\$0 copay	\$0 copay
• Urgent care center	\$0 copay	\$0 or 20% of the cost
Nuclear medicine and services		
• Freestanding radiological facility	\$0 copay	\$0 or 20% of the cost
• Outpatient hospital	\$0 copay	\$0 or 20% of the cost
Sleep study		
• Member's home	\$0 copay	\$0 or 20% of the cost
• Outpatient hospital	\$0 copay	\$0 or 20% of the cost
• Specialist's office	\$0 copay	\$0 or 20% of the cost
Therapeutic radiology (Radiation therapy)		
• Freestanding radiological facility	\$0 copay	\$0 or 20% of the cost
• Outpatient hospital	\$0 copay	\$0 or 20% of the cost
• Specialist's office	\$0 copay	\$0 or 20% of the cost



HEARING SERVICES

Medicare-covered hearing	\$0 copay	\$0 or 20% of the cost
Mandatory supplemental hearing benefit	HER945 \$0 copay for routine hearing exams up to 1 per year. \$0 copay for each Advanced level hearing aid up to 1 per ear every 3 years. Hearing aid purchase includes: - Unlimited follow-up provider visits during first year following	Hearing aids must be purchased through TruHearing. Coverage will not be provided for hearing aids purchased from a non-participating provider. If a provider is not in our network, you may have to pay upfront and submit a request for reimbursement. See Chapter 2 Payment Requests Contact

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 WHAT YOU PAY ON THIS HUMANA PLAN

- TruHearing hearing aid purchase
- 60-day trial period
- 3-year extended warranty
- 80 batteries per aid for non-rechargeable models
- Advanced hearing aids are available in rechargeable style options.

You must see a TruHearing provider to use this benefit. Call 844-255-7144 to schedule an appointment (TTY: 711).

OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN

Information or visit **Humana.com** for information on requesting reimbursement.



DENTAL SERVICES

Medicare-covered dental

\$0 copay

\$0 or **20%** of the cost

Mandatory supplemental dental benefit

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

DEN245

- **\$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.
- **\$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years.
- **\$0** copay for bridge recementation, bridges-pontic, crown recementation, panoramic film or diagnostic x-rays up to 1 every 5 years.
- **\$0** copay for bridges-crown up to 2 every 5 years.
- **\$0** copay for crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime.

DEN245

- **\$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.
- **\$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years.
- **\$0** copay for bridge recementation, bridges-pontic, crown recementation, panoramic film or diagnostic x-rays up to 1 every 5 years.
- **\$0** copay for bridges-crown up to 2 every 5 years.
- **\$0** copay for crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime.

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

Humana.



Medical Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
each plan is available at Humana.com/sb. In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule (but any applicable coinsurance payment still applies). Visiting an in-network provider may result in significant savings. The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator for our nationwide network can be found at Humana.com/FindCare. Out-of-network dentists have not agreed to provide services at contracted fees. The out-of-network provider may bill the member for more than what the plan pays, even for services listed with no member cost share. Members are responsible for this difference between Humana's reimbursement and the out-of-network provider's charges. This is known as balance billing. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Members may be billed by the out-of-network provider for any	• \$0 copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • \$0 copay for emergency diagnostic exam up to 1 per year. • \$0 copay for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • \$0 copay for periodontal maintenance up to 4 per year. • \$0 copay for necessary anesthesia with covered service up to as needed with covered codes per year. • \$0 copay for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year. • \$1,500 combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.	• \$0 copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • \$0 copay for emergency diagnostic exam up to 1 per year. • \$0 copay for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • \$0 copay for periodontal maintenance up to 4 per year. • \$0 copay for necessary anesthesia with covered service up to as needed with covered codes per year. • \$0 copay for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year. • \$1,500 combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

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



Medical Benefits (cont.)

IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN

OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN

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 **Humana.com** for information on requesting reimbursement.



VISION SERVICES

Eyewear (post cataract surgery)	\$0 copay	\$0 or 20% of the cost
Medicare-covered diabetic eye exam	\$0 copay	\$0 copay
Medicare-covered vision services The provider locator for Medicare-covered vision can be found at Humana.com/FindCare .	\$0 copay	\$0 or 20% of the cost
Mandatory supplemental vision benefit Please inform the network provider that you are part of the Humana Medicare Insight Network. NOTE: The network of providers for your supplemental vision benefits through Humana Medicare Insight Network may be different than the network of	VIS703 • \$0 copay for routine exam up to 1 per year. • \$40 combined maximum benefit coverage amount per year for routine exam. • \$350 maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames,	VIS703 • \$0 copay for routine exam up to 1 per year. • \$40 combined maximum benefit coverage amount per year for routine exam. • \$350 maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames,

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 WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
providers for the Medicare-covered vision benefits. The mandatory supplemental vision benefits are provided through the Humana Medicare Insight Network. The provider locator can be found at Humana.com/FindCare. Benefit allowance is applied toward the retail price. Member is responsible for any costs above the plan approved amount. Lost or broken materials are not covered. This benefit is limited to a one-time use per year. Any remaining benefit dollars do not "roll over" to a future purchase. Eyeglass lens options may be available with the maximum 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.	fitting for eyeglasses-lenses and frames. • OR • \$450 maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year. • Maximum benefit coverage amounts cannot be combined. PLUS providers are part of the Humana Medicare Insight Network and are indicated in the provider locator search results.	fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. • Maximum benefit coverage amounts cannot be combined.

MENTAL HEALTH SERVICES

Inpatient

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

\$0 copay

\$0 or \$2,080 copay per admit

*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 WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
Mental health therapy visits		
• Outpatient hospital	\$0 copay	\$0 or 20% of the cost
• Specialist's office	\$0 copay	\$0 or 20% of the cost
• Telehealth	\$0 copay	Not Covered
Outpatient substance abuse services		
• Outpatient hospital	\$0 copay	\$0 or 20% of the cost
• Specialist's office	\$0 copay	\$0 or 20% of the cost
• Telehealth	\$0 copay	Not Covered
SKILLED NURSING FACILITY		
This plan covers up to 100 days in a SNF	\$0 copay	\$0 copay per day for days 1-20 \$0 or \$218 copay per day for days 21-100
AMBULANCE		
	\$0 copay	\$0 or \$335 copay per date of service
TRANSPORTATION		
	Not Covered	
MEDICARE PART B DRUGS		
Allergy shots and serum		
• PCP's office	\$0 copay	\$0 copay
• Specialist's office	\$0 copay	\$0 copay
Chemotherapy drugs		
• Outpatient hospital	\$0 copay	\$0 or 20% of the cost
• Specialist's office	\$0 copay	\$0 or 20% of the cost
Other Part B drugs		
• Outpatient hospital	\$0 copay	\$0 or 20% of the cost
• PCP's office	\$0 copay	\$0 or 20% of the cost
• Pharmacy	\$0 copay	\$0 copay
• Specialist's office	\$0 copay	\$0 or 20% of the cost
Part B Insulin		
• Outpatient hospital	\$0 copay	\$0 or 20% of the cost
• PCP's office	\$0 copay	\$0 or 20% of the cost
• Pharmacy	\$0 copay	\$0 copay
• Specialist's office	\$0 copay	\$0 or 20% of the cost

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

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 Prescription Drug Benefits

PLAN HIGHLIGHTS

Extra Help

Most of our members qualify for and are getting Extra Help from Medicare to pay for their prescription drug plan costs. If you are in the Extra Help program, please refer to the Extra Help section below to view your deductible and initial coverage stage cost shares.

100-day supply

Up to 100-day supply on eligible drugs

Insulin costs

You won't pay more than **\$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan.

\$0 vaccines

\$0 copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

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.

DEDUCTIBLE

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

INITIAL COVERAGE

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

Pharmacy Cost-Sharing

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

To find which pharmacies are available in our network, go to [Humana.com/pharmacyfinder](https://www.humana.com/pharmacyfinder).

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

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

Insulin Cost-Sharing

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

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

To find which pharmacies are available in our network, go to [Humana.com/pharmacyfinder](https://www.humana.com/pharmacyfinder).

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

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CATASTROPHIC COVERAGE

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

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 WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
Acupuncture services (Medicare-covered)	\$0 copay for acupuncture for chronic low back pain up to 20 visit(s) per year.	\$0 or 20% coinsurance for acupuncture for chronic low back pain visits up to 20 visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Chiropractic services (Medicare-covered)	\$0 copay	\$0 or 20% of the cost
Podiatry services (Medicare-covered)	\$0 copay	\$0 or 20% of the cost
MEDICAL EQUIPMENT/SUPPLIES		
Continuous glucose monitor (CGM)		
• DME provider	\$0 copay	\$0 or 20% of the cost
• Pharmacy	\$0 copay	\$0 copay
Diabetic monitoring supplies		
• Diabetic supplier	\$0 copay	\$0 or 20% of the cost
• Network retail pharmacy	\$0 copay	\$0 or 20% of the cost
• Preferred diabetic supplier	\$0 copay	Not Covered
Durable medical equipment (DME)	\$0 copay	\$0 or 20% of the cost
Medical supplies at medical supplier	\$0 copay	\$0 or 20% of the cost
Prosthetic devices and related supplies	\$0 copay	\$0 or 20% of the cost



Additional benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
REHABILITATION SERVICES		
Cardiac rehabilitation services		
• Outpatient hospital	\$0 copay	\$0 or 20% of the cost
• Specialist's office	\$0 copay	\$0 or 20% of the cost
Occupational therapy		
• Comprehensive outpatient rehab facility	\$0 copay	\$0 or 20% of the cost
• Outpatient hospital	\$0 copay	\$0 or 20% of the cost
• Specialist's office	\$0 copay	\$0 or 20% of the cost
Physical therapy		
• Comprehensive outpatient rehab facility	\$0 copay	\$0 or 20% of the cost
• Outpatient hospital	\$0 copay	\$0 or 20% of the cost
• Specialist's office	\$0 copay	\$0 or 20% of the cost
Pulmonary rehabilitation services		
• Outpatient hospital	\$0 copay	\$0 or 20% of the cost
• Specialist's office	\$0 copay	\$0 or 20% of the cost
Speech therapy		
• Comprehensive outpatient rehab facility	\$0 copay	\$0 or 20% of the cost
• Outpatient hospital	\$0 copay	\$0 or 20% of the cost
• Specialist's office	\$0 copay	\$0 or 20% of the cost
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)		
• Outpatient hospital	\$0 copay	\$0 or 20% of the cost
• Specialist's office	\$0 copay	\$0 or 20% of the cost



Medicaid Benefit Comparison

The benefits described in the Covered Medical and Hospital Benefits sections above are covered by HumanaChoice SNP-DE H5216-388 (PPO D-SNP). For each benefit listed below, you can see what Michigan Department of Health & Human Services (Medicaid) covers and what this plan covers.

All Medicaid benefits are subject to Michigan Department of Health & Human Services (Medicaid) eligibility guidelines and requirements and are available only to full dual eligible individuals. If you have questions about your Medicaid eligibility and what benefits you are entitled to, review your member handbook or contact Michigan Department of Health & Human Services (Medicaid) at 800-642-3195 (toll free) 711 (TTY).

BENEFIT	MEDICAID BENEFIT	THIS PLAN BENEFIT
Ambulance	Covered	Covered
Ambulatory surgical center	Covered	Covered
Dentures	Covered	Not Covered
Diagnostic services, labs, and imaging	Covered	Covered
Doctor visits	Covered	Covered
Emergency care	Covered	Covered
Eyeglasses	Covered	Covered
Hearing aids	Covered	Covered
Home and community based waiver service programs	Covered	Not Covered
Inpatient hospital	Covered	Covered
Inpatient mental health services, nursing facility and intermediate care facility services in institutions for mental diseases (MD), age 65 and older	Covered	Covered with limitations
Inpatient mental health services, under age 21	Covered	Covered with limitations
Intermediate care facilities for individuals with intellectual disabilities (ICFs-IID)	Covered	Not Covered
Medicare Part B drugs	Covered	Covered
Mental health services	Covered	Covered

BENEFIT	MEDICAID BENEFIT	THIS PLAN BENEFIT
Nursing facility services, other than in an institution for mental diseases	Covered	Covered with limitations
Outpatient hospital coverage	Covered	Covered
Physical, occupational, speech therapy	Covered	Covered
Preventive care	Covered	Covered
Skilled nursing facility	Covered	Covered
Transportation	Covered	Not Covered
Urgently needed services	Covered	Covered



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**.

Humana Healthy Options Allowance™*

\$175 monthly allowance on a prepaid spending card.

All plan members receive this amount to buy approved over the counter (OTC) health and wellness products at participating retailers or through the plan's approved OTC mail order vendor.

Plus, members may also use this money for eligible groceries, utilities, rent, and more if they have certain qualifying chronic condition(s) and meet other program criteria.

Any unused amount rolls over each month and expires at the end of the plan year or upon disenrollment, whichever occurs first.

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

Travel Coverage

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

Smoking cessation program

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

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

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

* This spending allowance is a special program(s) for members with specific health conditions. Qualifying conditions include diabetes mellitus, cardiovascular disorders, chronic and disabling mental health conditions, chronic lung disorders, or chronic heart failure, among others. Some plans require at least two conditions and other requirements apply. See the plan's Evidence of Coverage for details. If you use this program for rent or utilities, Housing and Urban Development (HUD) requires it to be reported as income if you seek assistance. Contact your local HUD office if you have questions.

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

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

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

Limited to 4 times per year.

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

Rewards and Incentives - Go365® by Humana

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



Find out **more**



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



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

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

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

HumanaChoice SNP-DE H5216-388 (PPO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2026 based on a review of the HumanaChoice SNP-DE H5216-388 (PPO D-SNP) Model of Care.

If you get Medicare cost-share assistance, HumanaChoice SNP-DE H5216-388 (PPO D-SNP) providers aren't allowed to collect or bill you for services and items covered under Medicare Part A and Part B, including deductibles, coinsurance, and copayments – even when Medicaid payment is zero or a provider chooses to not submit to Medicaid. If a provider asks you to pay, that's against the law. You may however be responsible for a small Medicaid copayment.

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

Your provider may choose to submit to Michigan Department of Health & Human Services (Medicaid) for consideration of additional secondary payment for an amount applied to deductibles, coinsurance, or copayments. If you are cost-share protected, providers are required by federal regulation to accept HumanaChoice SNP-DE H5216-388 (PPO D-SNP) primary payment and Michigan Department of Health & Human Services (Medicaid) secondary payment as payment in full for covered Medicare Part A and Part B services – even when the Medicaid payment is zero or a provider chooses to not submit to Medicaid.



Find out **more** *(Continued)*

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**.

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Notice of Availability - Auxiliary Aids and Services Notice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GHHNOA2025HUM_0425

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

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

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

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

Diné [Navajo]: Saad t'áá jiik'eh, t'áadoole'é binahjì' bee adahodoonííígíí diné bich'í' anídahazt'i'í, dóó łahgo át'éego bee hada'dilyaaígíí bee bika'aanída'awo'í dahóló. Kohjì' hodíílnih **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 serbisyon 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.

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

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 ያላቸው አገልግሎቶችን ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

Bàsàw` [Bassa]: Wuḍu-xwíníín-mú-zà-zà kùà, Hwòdǒ-fàgá-nyo, kè nyo-boŭn-po-kà bě bé nyuεε se wídí pɛ̀ɛ-pɛ̀ɛ 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 isẹ àtilẹhìn ìrànlowọ̀ èdè, àti ọ̀nà kíkà míràn wà lárọ̀wọ̀tó. Pe **877-320-1235 (TTY: 711)**.

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

Humana.

Notes

[illegible]

Notes

H5216388000

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/20260016PDG** or scan the QR code with your smartphone or tablet's camera.



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



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

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Care and communication on your terms

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

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

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



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

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



How to get started*

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

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

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

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

Humana.

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Consent for release of protected health information

Member information (person whose information will be released):
Name: _____ Date of birth: _____ / _____ / _____

First Middle Last Month Day Year

Address: _____

Street City State ZIP

Member ID: _____ Group # (if applicable): _____
Phone #: _____ ☐ Home ☐ Cell*

I understand that this authorization will allow Humana and its affiliates to use or disclose the protected health[†] information (PHI) described below: (Please check only **one** box)

☐ Full Disclosure: Any protected health information Humana and its affiliates maintains, including mental health, HIV, health status or substance use or disorder records. This also includes sharing information on mail-order pharmacy, wellness products, and health programs with the person being authorized.

☐ Limited Disclosure: You specify what PHI to share, e.g., condition or treatment information, a specific date range, or product type. Unless you limit by product type, information will apply to all products and services. _____

If Limited Disclosure was selected please indicate which product(s) apply:

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

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

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

First Middle Last Required Field Month Day Year

Or if organization: _____

Name

Address: _____

Street City State ZIP

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

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



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.

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Scope of Appointment

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

☐ Medicare Advantage plans (Part C)

☐ Dental plans

☐ Stand-alone prescription drug plans (Part D)

☐ Vision plans

☐ Medicare Supplement plans

☐ Hospital Indemnity plans

Name _____

Phone _____

Address (Street, City, State ZIP code) _____

Relationship to the beneficiary _____

Medicare ID number (optional) _____

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

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

Beneficiary or legally authorized representative signature and signature date:

Signature _____

Signature date ____/____/____

To be completed by agent: (Please print)

Agent name _____

Agent phone _____

Agent SAN _____

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.

2026 Enrollment Form

Dual Eligible Special Needs Plan Enrollment Form

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

Follow these easy steps to become a Humana Medicare member



Have both your Medicare and Medicaid cards ready

Each individual applying must fill out a separate form.



Sign and date the enrollment form

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



Submit your enrollment form

You may fax the Member Services pages of this enrollment form to: **1-877-889-9923**. Or mail this enrollment form to:

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

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



Call us with questions

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

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

Instructions

- Completely fill the ovals.
- Use black ink only.
- Print only one clear number or capital block letter in each box.

- If you make a mistake, fix it by crossing out the box with an X. Put in the correct letter or number above or below the box as shown:

Correct numbers and letters

1 2 3 S M I ~~X~~ H
 T

Humana®

Additional Notes

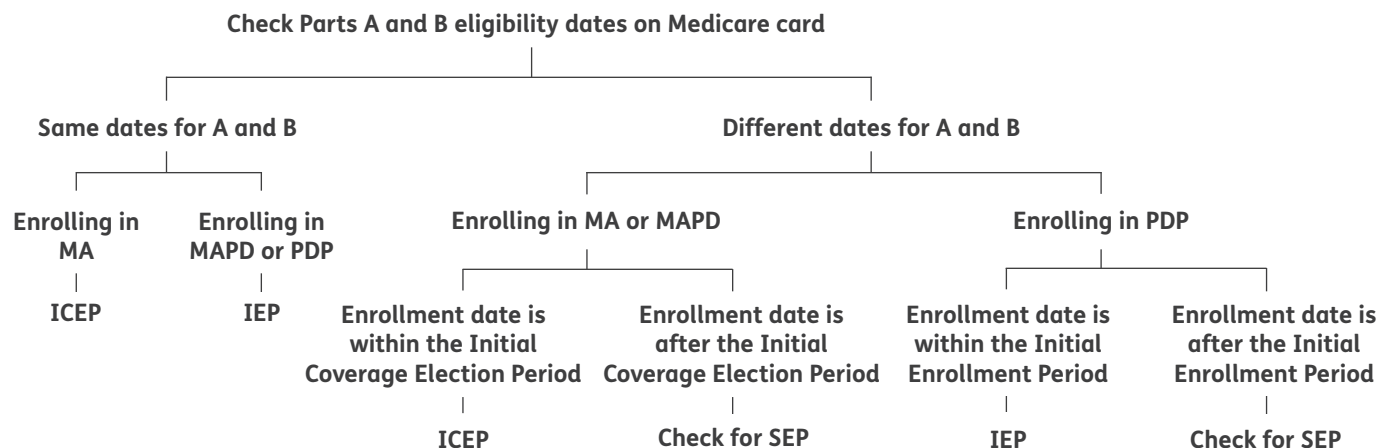
Asterisks (*) indicate required fields
Answering non-required fields is your choice. You can't be denied coverage if you don't complete them.

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

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

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

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



Scope Of Appointment (SOA) (Page 8)

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

F2F – Face to Face

INH – In Home Appointment

OTH – Other

RET – Retail Partner

SEM – Seminar

TEL – Telephonic

WAL – Walmart

Notice of Non-Discrimination

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

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

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

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

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

California members:

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

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

GHHNDN2025HUM

Notice of Availability - Auxiliary Aids and Services Notice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GHHNOA2025HUM_0425

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

ភាសាខ្មែរ [Khmer]: សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជំនួយផ្សេងៗដល់សមាជិក។ 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, ຊ່ວຍເຫຼືອແລະ ຮູບແບບທາງເລືອກອື່ນໃຫ້ໄດ້.
ໂທ **877-320-1235 (TTY: 711)**.

Diné [Navajo]: Saad t'áá jiik'eh, t'áadoole'é binahji' bee adahodooníłgíí diné bich'í' anídahazt'i'í, dóó łahgo át'éego bee hada'dilyaaígíí bee bika'aanída'awo'í dahóló. Kohji' hodíłnih **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.

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

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 አገዥ ማዳረግ እና አማራጭ ቅርፅ ያላቸው አገልግሎቶች ይገኛሉ። ለ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

Bàsà [Bassa]: Wuḍu-xwínín-mú-zà-zà kùà, Hwòdǒ-fǎnǎ-nyo, kè nyo-boŭn-po-kà bɛ bé nyuɛ se wíqí pɛ̀ɛ-pɛ̀ɛ 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)**.

Ọ̀yìnbo [Yoruba]: Àwọn isẹ àtìlẹ̀hìn ìrànlọ̀wọ̀ 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 ।



PLEASE READ THIS IMPORTANT INFORMATION

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

By completing this enrollment form, I agree to the following:

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

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

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

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

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

- If you are requesting membership in a **Dual Eligible Special Needs Plan (D-SNP)**, the following statement applies: I understand this plan is for individuals with both Medicaid and Medicare. My ability to enroll is based on verification that I am entitled to both Medicare and medical assistance under Medicaid.

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

For **INDIANA** applicants of a D-SNP: I understand that my signature on this enrollment form gives Humana and the state of Indiana permission to enroll me into Humana's Medicaid Managed Care plan that aligns with this Humana D-SNP.

For **TENNESSEE** applicants of a D-SNP: I understand that TennCare is not responsible for payment for these benefits, except for appropriate cost sharing amounts. TennCare is not responsible for guaranteeing the availability or quality of these benefits. Any reference to more, extra or additional Medicare benefits, is applicable to Medicare only and does not indicate increased Medicaid benefits.

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

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

Release of Information:

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

Privacy Act Statement:

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

Individuals experiencing homelessness:

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

2026 Humana Medicare Dual Eligible Special Needs Plan Enrollment Form

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

Print clearly. Use black ink.

Asterisks (*) indicate required fields.

AGENT NUMBER (SAN)
DATE OF BIRTH* SEX* ☐ F ☐ M
MEMBER ID NUMBER
H

(For current or past Humana members)

Please see your agent to complete these questions.

PROPOSED COVERAGE START DATE*

- -

(Must be after the sign date on page 8)

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

(See Additional Notes page)

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

LAST NAME*

FIRST NAME*

MI

MEDICARE NUMBER*

- -

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL (PART A) - -

MEDICAL (PART B) - -

RESIDENTIAL ADDRESS* P.O. Box not allowed.

☐ Experiencing homelessness

CITY*

APT or STE

ST*

ZIP*

COUNTY*

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

CITY

APT or STE

ST

ZIP

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

TELEPHONE

TELEPHONE TYPE

() - ☐ Cellphone ☐ Home (landline)

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

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

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

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

PCP ID NUMBER

PRIMARY CARE PHYSICIAN (PCP)

Are you already a patient of the physician you chose?

☐ Yes ☐ No

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

SEP Code	Special Election Period (SEP) statements
☐ LEC	I am either losing/leaving coverage I had from an employer or union or lost this type of coverage within the last two months.
☐ NLS	I had a change in my Extra Help paying for Medicare prescription drug coverage (newly got assistance, had a change in level or lost eligibility) within the last three months.
☐ MCD	I had a change in my Medicaid status (newly got assistance, had a change in level or lost eligibility) within the last three months.
☐ MOV	I am moving or have moved within the last two months. The move is either outside the service area for my current plan or this plan is a new option for me.
☐ SNP	I have been notified that I no longer qualify for my Dual Eligible Special Needs Plan and am in a period of deemed continued eligibility or I was disenrolled from my Dual Eligible Special Needs Plan within the past three months due to a Medicaid change or loss.
☐ INT	I have both Medicare and full Medicaid benefits, and want to enroll into an integrated Dual Eligible Special Needs Plan. Note: This SEP is valid once per month throughout each year, and only for enrollment into a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP), Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP), or Applicable Integrated Plan (AIP).
☐ EOC	My existing Medicare Advantage (MA) plan is ending its contract for the upcoming contract year. Note: This SEP is only valid from December 8 through the last day of February.
☐ OTH	None of the above statements apply to me. However, I feel I have a special circumstance which allows me an exception to enroll. Humana will contact you to determine if an exception can be granted. Must include the reason below.

Notes (if OTH):

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

N A E N - A E N - A A N N

Plan selection

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

CONTRACT* PBP* SEGMENT
 0 0

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

BASE MONTHLY PREMIUM*
\$.

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

I would like ONE of the following options:*

- ☐ Humana Gold Plus® HMO D-SNP
- ☐ Humana Dual Select HMO D-SNP
- ☐ Humana Community HMO D-SNP
- ☐ Humana Fully Integrated HMO D-SNP
- ☐ Humana Dual Fully Integrated HMO D-SNP
- ☐ Humana PathWays Dual Care HMO D-SNP
- ☐ Humana Dual Integrated HMO D-SNP
- ☐ HumanaChoice® PPO D-SNP
- ☐ Humana Dual Select PPO D-SNP

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

MEDICAID NUMBER

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

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

N A E N - A E N - A A N N

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

I will have other prescription drug coverage

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

NAME OF OTHER COVERAGE

ID NUMBER FOR THIS COVERAGE

GROUP NUMBER FOR THIS COVERAGE

Once enrolled, will you or your spouse work?

Yes No

Preferred Written Language (when available)

English Spanish Chinese Korean Other

Preferred Verbal Language

English Spanish Mandarin Cantonese
Korean Other

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

Audio Large print Accessible screen reader PDF
Oral over the phone Braille Data CD

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

APPLICANT MEDICARE NUMBER*

MEMBER SERVICES PAGE 7

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

N A E N - A E N - A A N N

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

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

SIGNATURE DATE*

M M - D D - 2 0 Y Y

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

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

LAST NAME	FIRST NAME	MI
STREET ADDRESS		
CITY	ST	ZIP
TELEPHONE	RELATIONSHIP TO APPLICANT	
() -		

FOR INDIVIDUALS HELPING AN APPLICANT WITH COMPLETING THIS FORM ONLY

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

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

AGENT USE ONLY

APPOINTMENT TYPE	SCOPE OF APPOINTMENT ID NUMBER		
WRITING AGENT NAME*			
AGENT NUMBER (SAN)*	DATE*		
	M M - D D - 2 0 Y Y		
AFFINITY PARTNER	LOCATION	CAMPAIGN	
REFERRING AGENT NAME			
REFERRING AGENT NUMBER (SAN)	CONTRACT*	PBP*	SEGMENT
			0 0

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

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

LEAD SOURCE*

☐ Book of Business ☐ Event ☐ Marketing/Advertisement ☐ Third-Party ☐ Humana



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

Receipt of Enrollment form

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

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

☐ I have read and reviewed the Summary of Benefits.

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

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

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

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



Humana Customer Care

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

Oct. 1 – Mar. 31

Daily

8 a.m. – 8 p.m.

Apr. 1 – Sept. 30

Monday – Friday

8 a.m. – 8 p.m.

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

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

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

IMPORTANT INFORMATION:

2026 Medicare Star Ratings

Official U.S.
Government
Medicare
Information



Humana - 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

Humana Healthy Options Allowance®

The plan may include an allowance to help pay for covered over-the-counter items and, if you have an eligible chronic condition that meets certain criteria, for eligible groceries and more.****

Humana.com/Medicare/Medicare-Programs/Healthy-Options-Allowance

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 **855-599-5751 (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.

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.

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

**** Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply. Healthy Options Allowance is part of a special supplemental program for chronically ill members on Special Needs Plans with one or more qualifying conditions, such as: diabetes mellitus, cardiovascular disorders, chronic and disabling mental health conditions, chronic lung disorders, chronic heart failure. Members on other plans must have two or more qualifying conditions. This is not a complete list of qualifying conditions. Having a qualifying condition alone does not mean you will receive the benefit(s). Other requirements may apply. Please see your Evidence of Coverage for more information.

HUD requires people who use plan benefits, including but not limited to Healthy Options Allowance, to pay rent and/or utilities to include it in the calculation of income. Should you have any additional questions or concerns about what must be included in the calculation of income, please contact your local HUD Field Office.

Humana is a Dual Eligible Special Needs HMO SNP, PPO SNP Plan with a Medicare contract and a contract with the state Medicaid program. Enrollment in this Humana plan depends on contract renewal.

† Prescription drug coverage can vary across plans. \$0 copay may be limited to specific tiers, coverage stages, 3-month supply and certain mail-order pharmacies.

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, formulary, pharmacy network, premium and/or copayments/co-insurance 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.

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.

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.