2026

Summary of Benefits

Humana Gold Plus H5619-119 (HMO)

San Luis Obispo

San Luis Obispo County

Our service area includes the following county/counties in California: San Luis Obispo.

* www.ccpnhpn.com is the HMO Group

Monthly Premium, Deductible and Limits

Monthly plan premium	**$0** You must keep paying your Medicare Part B premium.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	**$0** deductible for Tier 1, Tier 2 and Tier 3 **$615** deductible for Tier 4 and Tier 5
Medical Maximum out-of-pocket responsibility	**$720** in-network The most you pay for copays, coinsurance and other costs for covered medical services for the year.

Medical Benefits

INPATIENT HOSPITAL COVERAGE	
This plan covers an unlimited number of days for an inpatient stay	**$0** copay per admit
OUTPATIENT HOSPITAL COVERAGE	
Diagnostic colonoscopy	**$0** copay
Diagnostic mammography	**$0** copay
Surgery services	**$0** copay
AMBULATORY SURGERY CENTER	
Diagnostic colonoscopy	**$0** copay
Surgery services	**$0** copay
DOCTOR VISITS	
Primary Care Provider (PCP)	• PCP's office: **$0** copay • Telehealth: **$0** copay
Specialist	• Specialist's office: **$0** copay • Telehealth: **$0** copay

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." 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.)

PREVENTIVE CARE

This plan covers all Medicare preventive services including:

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

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

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

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

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

$0 copay

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

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

EMERGENCY CARE

Emergency services at emergency room
If you are admitted to the same hospital within 24 hours for the same condition, you pay $0 for the emergency care you received. **We cover emergency services worldwide. If you have an emergency outside of the U.S. and its territories, you will be responsible to pay for the rendered service(s) upfront and can request reimbursement.**

$150 copay

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Medical Benefits (cont.)

URGENTLY NEEDED SERVICES

Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. **We cover urgently needed services worldwide. If you have an urgently needed service outside of the U.S. and its territories, you will be responsible to pay for the rendered service(s) upfront and can request reimbursement.**	• Telehealth: **$65** copay • Urgent care center: **$65** copay

DIAGNOSTIC SERVICES, LABS & IMAGING

Advanced imaging services (MRI, MRA, PET and CT scans)	• Freestanding radiological facility: **$200** copay • Outpatient hospital: **$300** copay • PCP's office: **$200** copay • Specialist's office: **$200** copay
Basic radiological services (X-rays)	• Freestanding radiological facility: **$20** copay • Outpatient hospital: **$60** copay • PCP's office: **$0** copay • Specialist's office: **$0** copay • Urgent care center: **$65** copay
Diagnostic mammography	• Freestanding radiological facility: **$0** copay • Specialist's office: **$0** copay
Diagnostic procedures and tests	• Outpatient hospital: **$0** copay • PCP's office: **$0** copay • Specialist's office: **$0** copay • Urgent care center: **$65** copay
Lab services	• Freestanding laboratory: **$0** copay • Outpatient hospital: **$0** copay • PCP's office: **$0** copay • Specialist's office: **$0** copay • Urgent care center: **$65** copay
Nuclear medicine and services	• Freestanding radiological facility: **$0** copay • Outpatient hospital: **$0** copay
Sleep study	• Member's home: **$0** copay • Outpatient hospital: **$0** copay • Specialist's office: **$0** copay
Therapeutic radiology (Radiation therapy)	• Freestanding radiological facility: **20%** of the cost • Outpatient hospital: **20%** of the cost • Specialist's office: **20%** of the cost

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Medical Benefits (cont.)

HEARING SERVICES

Medicare-covered hearing	**$0** copay
Mandatory supplemental hearing benefit	In-Network: **HER939** • **$0** copay for routine hearing exams up to 1 per year. • **$499** copay for each Advanced level hearing aid up to 1 per ear per year. • **$799** copay for each Premium level hearing aid up to 1 per ear per year. Hearing aid purchase includes: • Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models • Rechargeable style options available for Premium and Advanced aids for an additional **$50** per aid **You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (TTY: 711).**

DENTAL SERVICES

Medicare-covered dental	**$0** copay
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 each plan is available at **Humana.com/sb**.	In-Network: **DENC29** • **$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, crown recementation, panoramic film or diagnostic x-rays up to 1 every 5 years. • **$0** copay for crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime.

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Medical Benefits (cont.)

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

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

- **$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.
- **$0** copay for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning 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.
- **30%** of the cost for bridges-pontic, complete dentures, partial dentures up to 1 every 5 years.
- **30%** of the cost for bridges-crown up to 2 every 5 years.
- **$1,250** maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.

VISION SERVICES

Eyewear (post cataract surgery)	**$0** copay
Medicare-covered diabetic eye exam	**$0** copay
Medicare-covered vision services The provider locator for Medicare-covered vision can be found at **Humana.com/FindCare**.	**$0** copay
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 providers for the Medicare-covered vision benefits. The provider locator can be found at **Humana.com/FindCare**.	In-Network: **VIS735** • **$0** copay for routine exam up to 1 per year. • **$150** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • OR • **$250** maximum benefit coverage amount per year at PLUS Provider for contact lenses or

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Medical Benefits (cont.)

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.	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 will display the PLUS Provider indicator in the provider locator search results found at **Humana.com/FindCare**.
MENTAL HEALTH SERVICES	
Inpatient This plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$720** copay per admit
Mental health therapy visits	• Outpatient hospital: **$35** copay • Specialist's office: **$25** copay • Telehealth: **$25** copay
Outpatient substance abuse services	• Outpatient hospital: **$35** copay • Specialist's office: **$25** copay • Telehealth: **$25** copay
SKILLED NURSING FACILITY (SNF)	
This plan covers up to 100 days in a SNF	**$20** copay per day for days 1-20 **$218** copay per day for days 21-100
AMBULANCE	
Air	**20%** of the cost
Ground	**$335** copay per date of service
TRANSPORTATION	
	Not Covered

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Medical Benefits (cont.)

MEDICARE PART B DRUGS
Some rebatable Part B drugs may be subject to a lower coinsurance

Allergy shots and serum	• PCP's office: **$0** copay • Specialist's office: **$0** copay
Chemotherapy drugs	• Outpatient hospital: **20%** of the cost • Specialist's office: **20%** of the cost
Other Part B drugs	• Outpatient hospital: **20%** of the cost • PCP's office: **20%** of the cost • Pharmacy: **20%** of the cost • Specialist's office: **20%** of the cost
Part B Insulin You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan.	• Outpatient hospital: **20%** of the cost • PCP's office: **20%** of the cost • Pharmacy: **20%** of the cost • Specialist's office: **20%** of the cost

Prescription Drug Benefits

PLAN HIGHLIGHTS

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

DEDUCTIBLE

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

INITIAL COVERAGE

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

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Pharmacy Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		**Standard Mail-Order Cost-Sharing**		**Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy™	
Day supply	**30-day**	**100-day***	**30-day**	**100-day***	**30-day**	**100-day***
Tier 1: Preferred Generic	$0	$0	$10	$30	$0	$0
Tier 2: Generic	$10	$30	$20	$60	$10	$0
Tier 3: Preferred Brand	$47	$141	$47	$141	$47	$94
Tier 4: Non-Preferred Drug	50%	50%	50%	50%	50%	50%
Tier 5: Specialty Tier	25%	N/A	25%	N/A	25%	N/A

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

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

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

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

Insulin Cost-Sharing

	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	25% up to $10	25% up to $30	25% up to $20	25% up to $60	25% up to $10	$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 $70
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

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

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

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

CATASTROPHIC COVERAGE

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

EXCLUDED DRUG COVERAGE

Erectile dysfunction (ED) drugs	Select drugs covered at Tier 1 cost-share amount.
Prescription vitamins	Select drugs covered at Tier 1 cost-share amount.

*Refer to your Evidence of Coverage for more information on Excluded Drug coverage.

EXTRA HELP

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

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

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

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

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

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

Additional Benefits

Acupuncture services (Medicare-covered)	**$0** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.
Chiropractic services (Medicare-covered)	**$15** copay
Podiatry services (Medicare-covered)	**$0** copay

Additional Benefits (cont.)

MEDICAL EQUIPMENT/SUPPLIES	
Continuous glucose monitor (CGM)	• DME provider **$0** copay • Pharmacy: **$0** copay
Diabetic monitoring supplies	• Diabetic supplier: **10%** of the cost • Network retail pharmacy: **10%** of the cost • Preferred diabetic supplier: **$0** copay
Durable medical equipment (DME)	• DME provider: **20%** of the cost
Medical supplies	• Medical supplier: **20%** of the cost
Prosthetic devices and related supplies	• Prosthetics provider: **20%** of the cost
REHABILITATION SERVICES	
Cardiac rehabilitation services	• Outpatient hospital: **$0** copay • Specialist's office: **$0** copay
Occupational therapy	• Comprehensive outpatient rehab facility: **$0** copay • Outpatient hospital: **$0** copay • Specialist's office: **$0** copay
Physical therapy	• Comprehensive outpatient rehab facility: **$0** copay • Outpatient hospital: **$0** copay • Specialist's office: **$0** copay
Pulmonary rehabilitation services	• Outpatient hospital: **$0** copay • Specialist's office: **$0** copay
Speech therapy	• Comprehensive outpatient rehab facility: **$0** copay • Outpatient hospital: **$0** copay • Specialist's office: **$0** copay
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)	• Outpatient hospital: **$0** copay • Specialist's office: **$0** copay

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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 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.

Over-the-Counter (OTC) mail order
$100 quarterly allowance to buy approved over-the-counter health and wellness products available through our OTC Mail Order provider.

Unused amount rolls over to the next quarter and expires at the end of the plan year.

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

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

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

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

2026 Humana Medicare Enrollment Form

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

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

AGENT NUMBER (SAN) 1684173

DATE OF BIRTH* – – SEX* F M

MEMBER ID NUMBER
H
(For current or past Humana members)

MEDICARE HEALTH INSURANCE

LAST NAME*

FIRST NAME* MI

MEDICARE NUMBER*
– –

IS ENTITLED TO EFFECTIVE DATE
HOSPITAL (PART A) – 0 1 –
MEDICAL (PART B) – 0 1 –

Please see your agent to complete these questions.
PROPOSED COVERAGE START DATE*
– 0 1 – 2 0 2 6
(Must be after the sign date on page 8)

ICEP MA or MAPD | IEP PDP or MAPD | AEP | OEP | OEP NEW | OEPI | SEP CODE†
(See Additional Notes page)
†Required if SEP selected. See page 4 for code.

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

APT or STE

CITY* ST* ZIP*

COUNTY*

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

APT or STE

CITY ST ZIP

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

TELEPHONE TELEPHONE TYPE
( ) – Cellphone Home (landline)

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

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

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

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

PCP ID NUMBER

PRIMARY CARE PHYSICIAN (PCP)

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

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

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

Notes (if OTH):

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

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Plan selection

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

CONTRACT* PBP* SEGMENT
0 0

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

BASE MONTHLY PREMIUM*
$.

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

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

Humana Gold Plus® HMO
Humana Gold Plus® Giveback HMO
Humana USAA Honor Giveback HMO
Humana Essentials Plus Giveback HMO
Humana Gold Plus® HMO C-SNP
(Additional Pre-Qualification Form Required)
Humana Community HMO C-SNP
(Additional Pre-Qualification Form Required)
Humana Community HMO
Humana Select Partner Plan HMO
Humana Cleveland Clinic Preferred HMO
Humana LCMC Advantage HMO
Humana FMOL Network HMO
Humana Total Complete HMO
Humana Total Complete Giveback HMO

HumanaChoice® PPO
HumanaChoice® Giveback PPO
Humana USAA Honor Giveback PPO
Humana Essentials Plus Giveback PPO
HumanaChoice® PPO C-SNP
(Additional Pre-Qualification Form Required)
Humana Together in Health PPO I-SNP
(Additional Attestation Form Required)
Humana Together in Health Select PPO I-SNP
(Additional Attestation Form Required)
Humana Senior Living Plan PPO I-SNP
(Additional Attestation Form Required)
Humana USAA Honor Giveback with Rx PPO
Humana Full Access PPO
Humana Full Access Giveback PPO
Humana Value Plus PPO
Humana Value Choice PPO
Humana Direct Choice Giveback PPO
Humana Basic Rx Plan (PDP)
Humana Premier Rx Plan (PDP)
Humana Value Rx Plan (PDP)
Humana Gold Choice® PFFS

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

Asterisks (*) indicate required fields APPLICANT MEDICARE NUMBER*

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

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

MyOption℠ DEN972

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

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

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

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

NAME OF OTHER COVERAGE

ID NUMBER FOR THIS COVERAGE GROUP NUMBER FOR THIS COVERAGE

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

Preferred Written Language (when available)

English Spanish Chinese Korean Other _____

Preferred Verbal Language

English Spanish Mandarin Cantonese

Korean Other _____

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

Audio Large print Accessible screen reader PDF

Oral over the phone Braille Data CD

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

Asterisks (*) indicate required fields APPLICANT MEDICARE NUMBER*

– –

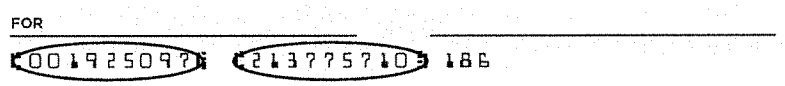
PLEASE SELECT ONE PREMIUM PAYMENT OPTION. You may pay your monthly plan premium and/or late enrollment penalty via automatic deduction from your bank account, Social Security Administration (SSA) or Railroad Retirement Board (RRB) benefit check, or credit or debit card. You may also choose to pay by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

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

Checking account Savings account

BANK NAME

ROUTING NUMBER ACCOUNT NUMBER



Routing number Account number

Social Security benefit check deduction (Please see note below)

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

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

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

Mastercard Visa Discover American Express

CREDIT OR DEBIT CARD NUMBER EXPIRATION DATE

– 2 0

Coupon book

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

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

Asterisks (*) indicate required fields APPLICANT MEDICARE NUMBER*

– –

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*

_____ – – 2 0

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*
Alan Kip Meredith

AGENT NUMBER (SAN)* DATE*
1684173 – – 2 0

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

Scope of Appointment Confirmation Form

This form must be completed and signed prior to an appointment to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person who has Medicare or their authorized representative.

Place a check mark in the box next to the type of products you want the agent to discuss. (See helpful descriptions on the next page.)

- ☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**
- ☐ **Medicare Advantage plans (Part C) and Medicare Cost plans**
  Medicare Health Maintenance Organization (HMO) plan, Medicare Preferred Provider Organization (PPO) plan, Medicare Private Fee-For-Service (PFFS) plan, Medicare Special Needs Plan (SNP), Medicare Medical Savings Account (MSA) plan, or Medicare Cost plan
- ☐ **Other health-related plans**
  Dental/vision/hearing products, supplemental health products, Medicare Supplement (Medigap) products

Signing this form does **not** obligate you to enroll in a plan, affect your current or future Medicare enrollment status, or automatically enroll you in the plans discussed.

Note: The person who will discuss the products is either employed or contracted by a Medicare plan. They don't work directly for the federal government. This person may also be paid based on your enrollment.

Beneficiary or authorized representative signature and signature date:

Signature: _____ Date: _____

If you are the authorized representative, sign above and print below:

Representative name: _____

Your relationship to the beneficiary: _____

To be completed by agent:

Agent name: Alan Kip Meredith	Agent phone: 805 548 8072
Agent address: 1303 Higuera San Luis Obispo, CA 93401	
Beneficiary name:	Beneficiary phone:
Beneficiary address:	
Initial method of contact (circle one): **Web** **Email** **Phone** **Text** **Walk-in**	
Agent signature: K. Meredith	
Products to be discussed: M.A.P.D.	
Date of appointment:	

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

Agent: Fax this side.