2026

# Summary of Benefits

## Humana Value Plus H5216-173 (PPO)

Wisconsin

Select Counties in Wisconsin

Our service area includes the following county/counties in Wisconsin: Brown, Calumet, Columbia, Crawford, Dane, Dodge, Door, Douglas, Fond du Lac, Forest, Green, Green Lake, Iowa, Jefferson, Kenosha, Kewaunee, Manitowoc, Marathon, Marinette, Marquette, Menominee, Milwaukee, Oconto, Outagamie, Ozaukee, Portage, Racine, Rock, Sauk, Sheboygan, Walworth, Washington, Waukesha, Waupaca, Waushara, Winnebago.

## 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

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

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# Let's talk about Humana Value Plus H5216-173 (PPO)

Find out more about the Humana Value Plus H5216-173 (PPO) plan – including the health and drug services it covers – in this easy-to-use booklet.

Humana Value Plus H5216-173 (PPO) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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

## To be eligible

To join Humana Value Plus H5216-173 (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

## Plan name

Humana Value Plus H5216-173 (PPO)

## How to reach us

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

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

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

**Humana.com/Medicare**

## More about Humana Value Plus H5216-173 (PPO)

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

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

As a member it's a good idea to select a doctor as your Primary Care Provider (PCP). Humana Value Plus H5216-173 (PPO) has a network of doctors, hospitals, pharmacies and other providers.

## A healthy partnership

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

# Monthly Premium, Deductible and Limits

**PLAN COSTS**

| | |
|---|---|
| **Monthly plan premium** | **$21.10**<br>If you receive premium assistance, this plan premium may be reduced.<br>You must keep paying your Medicare Part B premium. |
| **Part B premium reduction**[1] | Your plan will reduce your Monthly Part B premium by up to **$1** but by no more than Original Medicare's Part B Premium for 2026. |
| **Medical deductible**<br><br>*You pay the same amount as you would with Original Medicare. | **$283*** combined Part B deductible<br>The following services listed are excluded from the combined in-network and out-of-network Part B deductible:<br><br>In-Network only:<br>Ambulance Services<br>Chemotherapy Drugs and Administration<br>Continuous Glucose Monitor<br>Diabetic Monitoring Supplies<br>Diagnostic Colonoscopy<br>Diagnostic Mammography<br>Durable Medical Equipment<br>Other Medicare Part B Drugs<br>Outpatient Blood Services<br>Part A Services (Inpatient, Skilled Nursing, and Home Health)<br><br>Both In-Network and Out-of-Network:<br>Emergency Room Services<br>Medicare Covered Preventive Services<br>Medicare Part B Insulin Drugs<br>Services not covered by Original Medicare (i.e., Supplemental Benefits)<br>Urgently Needed Services at Urgent Care Centers |
| **Pharmacy (Part D) deductible** | **$615** deductible |
| **Medical Maximum out-of-pocket responsibility** | **$9,250** in-network<br>**$13,900** combined in- and out-of-network<br>The most you pay for copays, coinsurance and other costs for covered medical services for the year. |

[1]It could take several months for the Social Security Administration to complete their processing. This means you may not see the increase in your Social Security check for several months after the effective date of this plan. Any missed increases will be added to your next check after processing is complete.

*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

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **INPATIENT HOSPITAL COVERAGE** | | |
| This plan covers an unlimited number of days for an inpatient stay. | **$1,882** copay per admit | **50%** of the cost |
| **OUTPATIENT HOSPITAL COVERAGE** | | |
| **Diagnostic colonoscopy** | **$0** copay | **$0** copay |
| **Diagnostic mammography** | **$0** copay | **$0** copay |
| **Surgery services** | **20%** of the cost | **50%** of the cost |
| **AMBULATORY SURGERY CENTER** | | |
| **Diagnostic colonoscopy** | **$0** copay | **$0** copay |
| **Surgery services** | **20%** of the cost | **50%** of the cost |
| **DOCTOR VISITS** | | |
| **Primary care provider (PCP)** | | |
| • PCP's office | **$0** copay | **30%** of the cost |
| • Telehealth | **$0** copay | **Not Covered** |
| **Specialist** | | |
| • Specialist's office | **20%** of the cost | **30%** of the cost |
| • Telehealth | **20%** of the cost | **Not Covered** |
| **PREVENTIVE CARE** | | |
| This plan covers all Medicare preventive services including:<br>**Cancer Screenings**<br>• Breast cancer screening (mammogram)<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screening<br>• Lung cancer screening<br>• Prostate cancer screening<br><br>**Cardiovascular (heart) Care**<br>• Abdominal aortic aneurysm screening<br>• Cardiovascular disease risk reduction visit<br>• Cardiovascular disease screenings | **$0** copay | **$0** copay or **35%** of the cost, depending on the service and where service is provided. |

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## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Diabetes Care**<br>• Diabetes screenings<br>• Diabetes self-management training<br>• Medicare Diabetes Prevention Program (MDPP) | | |
| **Dietary Guidance and Support**<br>• Medical nutrition therapy<br>• Obesity screening and therapy | | |
| **Routine Screenings and Immunizations**<br>• Annual Wellness Visit (AWV)<br>• Immunizations<br>• Routine physical exam<br>• "Welcome to Medicare" preventive visit | | |
| **Screenings and Counseling Services**<br>• Bone mass measurement<br>• Depression screening<br>• Glaucoma screening<br>• HIV screening<br>• Screening & counseling to reduce alcohol misuse<br>• Sexually transmitted infections (STIs) screening and counseling<br>• Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)<br>Any additional preventive services approved by Medicare during the contract year will be covered. | | |

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## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **EMERGENCY CARE** | | |
| **Emergency services at emergency room**<br>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.** | **$115** copay | **$115** copay |
| **URGENTLY NEEDED SERVICES** | | |
| • **Telehealth**<br>• **Urgent care center**<br>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.** | **30%** of the cost<br>**30%** of the cost | **Not Covered**<br>**30%** of the cost |
| **DIAGNOSTIC SERVICES, LABS AND IMAGING** | | |
| **Advanced imaging services (MRI, MRA, PET and CT scans)** | | |
| • Freestanding radiological facility | **$200** copay | **50%** of the cost |
| • Outpatient hospital | **$335** copay | **50%** of the cost |
| • PCP's office | **$280** copay | **50%** of the cost |
| • Specialist's office | **$280** copay | **50%** of the cost |

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## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Basic radiological services (X-rays)** | | |
| • Freestanding radiological facility | **$65** copay | **50%** of the cost |
| • Outpatient hospital | **20%** of the cost | **50%** of the cost |
| • PCP's office | **$0** copay | **30%** of the cost |
| • Specialist's office | **20%** of the cost | **30%** of the cost |
| • Urgent care center | **30%** of the cost | **30%** of the cost |
| **Diagnostic mammography** | | |
| • Freestanding radiological facility | **$0** copay | **$0** copay |
| • Specialist's office | **$0** copay | **$0** copay |
| **Diagnostic procedures and tests** | | |
| • Outpatient hospital | **20%** of the cost | **50%** of the cost |
| • PCP's office | **$0** copay | **30%** of the cost |
| • Specialist's office | **20%** of the cost | **30%** of the cost |
| • Urgent care center | **30%** of the cost | **50%** of the cost |
| **Lab services** | | |
| • Freestanding laboratory | **$30** copay | **50%** of the cost |
| • Outpatient hospital | **20%** of the cost | **50%** of the cost |
| • PCP's office | **$0** copay | **50%** of the cost |
| • Specialist's office | **$0** copay | **50%** of the cost |
| • Urgent care center | **30%** of the cost | **50%** of the cost |
| **Nuclear medicine and services** | | |
| • Freestanding radiological facility | **20%** of the cost | **50%** of the cost |
| • Outpatient hospital | **20%** of the cost | **50%** of the cost |
| **Sleep study** | | |
| • Member's home | **$0** copay | **50%** of the cost |
| • Outpatient hospital | **20%** of the cost | **50%** of the cost |
| • Specialist's office | **20%** of the cost | **50%** of the cost |
| **Therapeutic radiology (Radiation therapy)** | | |
| • Freestanding radiological facility | **20%** of the cost | **30%** of the cost |
| • Outpatient hospital | **20%** of the cost | **50%** of the cost |
| • Specialist's office | **20%** of the cost | **30%** of the cost |

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## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **HEARING SERVICES** | | |
| **Medicare-covered hearing** | **20%** of the cost | **30%** of the cost |
| **Mandatory supplemental hearing benefit**<br>The provider locator for mandatory supplemental hearing benefits can be found at **Humana.com/FindCare**. | **HER763**<br>• **$0** copay for fitting/evaluation, routine hearing exams up to 1 per year.<br>• **$500** combined maximum benefit coverage amount for the choice of each OTC hearing aids or each prescription hearing aids (all types) up to 1 per ear per year. | **HER763**<br>• **$0** copay for fitting/evaluation, routine hearing exams up to 1 per year.<br>• **$500** combined maximum benefit coverage amount for the choice of each OTC hearing aids or each prescription hearing aids (all types) up to 1 per ear per year.<br>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.<br>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 Information or visit **Humana.com** for information on requesting reimbursement. |
| **DENTAL SERVICES** | | |
| **Medicare-covered dental** | **20%** of the cost | **30%** of the cost |
| **Mandatory supplemental dental benefit**<br>Limitations and exclusions may apply. Please see your Evidence of Coverage (EOC) for additional details. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. Dental benefits under | **DENB38**<br>• **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.<br>• **$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. | **DENB38**<br>• **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.<br>• **$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. |

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| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| 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**.<br><br>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**.<br><br>Out-of-network dentists have not agreed to provide services at contracted fees. **The out-of-network provider may bill the member for more that what the plan pays, even for services listed with no member** | • **$0** copay for bridge recementation, crown recementation, panoramic film or diagnostic x-rays up to 1 every 5 years.<br>• **$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.<br>• **$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.<br>• **$0** copay for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year.<br>• **$0** copay for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.<br>• **$0** copay for periodontal maintenance up to 4 per year.<br>• **$0** copay for necessary anesthesia with covered service up to as needed with covered codes per year.<br>• **$0** copay for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year.<br>• **30%** of the cost for bridges-pontic, complete dentures, partial dentures up to 1 every 5 years.<br>• **30%** of the cost for bridges-crown up to 2 every 5 years. | • **$0** copay for bridge recementation, crown recementation, panoramic film or diagnostic x-rays up to 1 every 5 years.<br>• **$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.<br>• **$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.<br>• **$0** copay for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year.<br>• **$0** copay for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.<br>• **$0** copay for periodontal maintenance up to 4 per year.<br>• **$0** copay for necessary anesthesia with covered service up to as needed with covered codes per year.<br>• **$0** copay for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year.<br>• **30%** of the cost for bridges-pontic, complete dentures, partial dentures up to 1 every 5 years.<br>• **30%** of the cost for bridges-crown up to 2 every 5 years. |

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## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **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 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. | • **$5,000** combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits. | • **$5,000** combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.<br>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |
| **VISION SERVICES** | | |
| **Eyewear (post cataract surgery)** | **$0** copay | **50%** of the cost |
| **Medicare-covered diabetic eye exam** | **$0** copay | **35%** of the cost |

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## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Medicare-covered vision services**<br>The provider locator for Medicare-covered vision can be found at **Humana.com/FindCare**. | **20%** of the cost | **30%** of the cost |
| **Mandatory supplemental vision benefit**<br>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**.<br>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.<br>This benefit is limited to a one-time use per year. Any remaining benefit dollars do not "roll over" to a future purchase.<br>Eyeglass lens options may be available with the maximum benefit coverage amount up to one pair per year.<br>Benefits are offered on a calendar basis. Any amount unused by the end of the year will expire.<br>Copayments, coinsurances, and deductibles paid for supplemental benefits do not count toward your maximum out-of-pocket amount. | **VIS711**<br>• **$0** copay for routine exam up to 1 per year.<br>• **$40** combined maximum benefit coverage amount per year for routine exam.<br>• **$250** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.<br>• OR<br>• **$350** maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.<br>• Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year.<br>• Maximum benefit coverage amount is limited to one time use per year.<br>• Maximum benefit coverage amounts cannot be combined.<br>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**. | **VIS711**<br>• **$0** copay for routine exam up to 1 per year.<br>• **$40** combined maximum benefit coverage amount per year for routine exam.<br>• **$250** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.<br>• Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year.<br>• Maximum benefit coverage amount is limited to one time use per year.<br>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.<br>• Maximum benefit coverage amounts cannot be combined. |

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## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **MENTAL HEALTH SERVICES** | | |
| **Inpatient**<br>This plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital | **$1,733** copay per admit | **50%** of the cost |
| **Mental health therapy visits** | | |
| • Outpatient hospital | **20%** of the cost | **50%** of the cost |
| • Specialist's office | **20%** of the cost | **30%** of the cost |
| • Telehealth | **20%** of the cost | **Not Covered** |
| **Outpatient substance abuse services** | | |
| • Outpatient hospital | **20%** of the cost | **30%** of the cost |
| • Specialist's office | **20%** of the cost | **30%** of the cost |
| • Telehealth | **20%** of the cost | **Not Covered** |
| **SKILLED NURSING FACILITY (SNF)** | | |
| This plan covers up to 100 days in a SNF | **$0** copay per day for days 1-20<br>**$218** copay per day for days 21-100 | **50%** of the cost for days 1-100 |
| **AMBULANCE** | | |
| **Air** | **20%** of the cost | **20%** of the cost |
| **Ground** | **$335** copay per date of service | **$335** copay per date of service |
| **TRANSPORTATION** | | |
| | Not Covered | |

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## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **MEDICARE PART B DRUGS**<br>Some rebatable Part B drugs may be subject to a lower coinsurance. | | |
| **Allergy shots and serum** | | |
| • PCP's office | **$0** copay | **$0** copay |
| • Specialist's office | **$0** copay | **$0** copay |
| **Chemotherapy drugs** | | |
| • Outpatient hospital | **20%** of the cost | **50%** of the cost |
| • Specialist's office | **20%** of the cost | **50%** of the cost |
| **Other Part B drugs** | | |
| • Outpatient hospital | **20%** of the cost | **50%** of the cost |
| • PCP's office | **20%** of the cost | **50%** of the cost |
| • Pharmacy | **$0** copay | **$0** copay |
| • Specialist's office | **20%** of the cost | **50%** of the cost |
| **Part B Insulin** | | |
| • Outpatient hospital | **20%** of the cost | **50%** of the cost |
| • PCP's office | **20%** of the cost | **50%** of the cost |
| • Pharmacy | **$0** copay | **$0** copay |
| • Specialist's office | **20%** of the cost | **50%** of the cost |
| You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan. | | |

## Prescription Drug Benefits

| | |
|---|---|
| **PLAN HIGHLIGHTS** | |
| **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 |
| **$0 vaccines** | **$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) |

**DEDUCTIBLE**

This plan has a **$615** deductible. You pay the full cost of your drugs until you reach **$615**. Then, you only pay your cost-share.

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## INITIAL COVERAGE

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

### Pharmacy Cost-Sharing

| | Retail Cost-Sharing Includes all in-network retail pharmacies | | Mail-Order Cost-Sharing | |
|---|---|---|---|---|
| **Day supply** | **30-day** | **100-day*** | **30-day** | **100-day*** |
| All Plan-Covered Part D Drugs | 25% | 25% | 25% | 25% |

You have several options for filling your prescriptions, including retail and mail-order pharmacies. CenterWell Pharmacy® is the 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, even if you haven't paid your deductible.

### Insulin Cost-Sharing

| | Retail Cost-Sharing Includes all in-network retail pharmacies | | Mail-Order Cost-Sharing | |
|---|---|---|---|---|
| **Day supply** | **30-day** | **100-day*** | **30-day** | **100-day*** |
| | 25% up to $35 | 25% up to $105 | 25% up to $35 | 25% up to $105 |
| All Plan-Covered Part D Insulins | $35 | $105 | $35 | $105 |

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

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

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

## CATASTROPHIC COVERAGE

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

**EXTRA HELP**

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

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

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

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

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

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

## Additional Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Acupuncture services (Medicare-covered)** | **20%** coinsurance for acupuncture for chronic low back pain visits up to 20 visit(s) per year. | **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)** | **$15** copay | **50%** of the cost |
| **Podiatry services (Medicare-covered)** | **20%** of the cost | **50%** of the cost |
| **MEDICAL EQUIPMENT/SUPPLIES** | | |
| **Continuous glucose monitor (CGM)** | | |
| • DME provider | **$0** copay | **20%** of the cost |
| • Pharmacy | **$0** copay | **20%** of the cost |

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## Additional Benefits (cont.)

| | | |
|---|---|---|
| **Diabetic monitoring supplies** | | |
| • Diabetic supplier | **20%** of the cost | **50%** of the cost |
| • Network retail pharmacy | **10%** of the cost | **50%** of the cost |
| • Preferred diabetic supplier | **$0** copay | **Not Covered** |
| **Durable medical equipment (DME)** | **20%** of the cost | **20%** of the cost |
| **Medical supplies at medical supplier** | **20%** of the cost | **50%** of the cost |
| **Prosthetics devices and related supplies at prosthetics provider** | **20%** of the cost | **50%** of the cost |
| **REHABILITATION SERVICES** | | |
| **Cardiac rehabilitation services** | | |
| • Outpatient hospital | **20%** of the cost | **50%** of the cost |
| • Specialist's office | **20%** of the cost | **50%** of the cost |
| **Occupational therapy** | | |
| • Comprehensive outpatient rehab facility | **20%** of the cost | **30%** of the cost |
| • Outpatient hospital | **20%** of the cost | **30%** of the cost |
| • Specialist's office | **20%** of the cost | **30%** of the cost |
| **Physical therapy** | | |
| • Comprehensive outpatient rehab facility | **20%** of the cost | **30%** of the cost |
| • Outpatient hospital | **20%** of the cost | **30%** of the cost |
| • Specialist's office | **20%** of the cost | **30%** of the cost |
| **Pulmonary rehabilitation** | | |
| • Outpatient hospital | **20%** of the cost | **50%** of the cost |
| • Specialist's office | **20%** of the cost | **50%** of the cost |
| **Speech therapy** | | |
| • Comprehensive outpatient rehab facility | **20%** of the cost | **30%** of the cost |
| • Outpatient hospital | **20%** of the cost | **30%** of the cost |
| • Specialist's office | **20%** of the cost | **30%** of the cost |
| **Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD)** | | |
| • Outpatient hospital | **20%** of the cost | **50%** of the cost |
| • Specialist's office | **20%** of the cost | **50%** of the cost |

# 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**.

**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.

**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**
**$125** 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.

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

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

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

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

# Find out **more**

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

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

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

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

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

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

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



The Part B Premium Reduction benefit pays part or all of your Part B premium and the amount may change based on the amount you pay for Part B premium.

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# 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 fòma 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]: નિઃશુલ્ક ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **877-320-1235 (TTY: 711)** પર કૉલ કરો.

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

हिन्दी [Hindi]: निःशुल्क 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**.

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

ភាសាខ្មែរ [Khmer]៖ សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ ទូរសព្ទទៅ លេខ **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 ຮູບແບບທາງເລືອກອື່ນໃຫ້ໃຊ້ຟຣີ. ໂທ **877-320-1235 (TTY: 711)**.

Diné [Navajo]: Saad t'áá jiik'eh, t'áadoole'é binahjį' bee adahodooníłígíí diné bich'į' anídahazt'i'í, dóó łahgo át'éego bee hada'dilyaaígíí bee bika'aanída'awo'í dahólǫ. Kohjį' hodíilnih **877-320-1235 (TTY: 711)**.

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

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

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫ਼ਤ 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.

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

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

አማርኛ [Amharic]፦ ቋንቋ፣ አጋዥ ማዳመጫ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችም ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

Bǎsɔ́ [Bassa]: Wuɖu-xwíníín-mú-zà-zà kǔà, Hwòɖǒ-fɔńɔ-ńnyɔ,́ kè nyɔ-bɔǔn-po-kà ɓě ɓé nyuɛɛ se wíɖí pɛ́è-pɛ́è ɖò kɔ.̃ **877-320-1235 (TTY: 711)** ɖá.

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

Òyìnbó [Yoruba]: Àwọn iṣẹ́ àtìlẹhìn ìrànlọ́wọ́ èdè, àti ọ̀nà kíkà míràn wà lárọwọ́tó. Pe **877-320-1235 (TTY: 711)**.

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

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# Notes

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

Important information about this plan

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