2024 **Health Plan Benefits** at a Glance

HumanaChoice H5216-308 (PPO) Delaware, Virginia

Plan Costs	With Medicare Only	With Medicare & State Cost-Share Protection
Monthly plan premium	$0	$0
Medicare Part B premium reduction	Your plan will reduce your Monthly Part B premium by up to $100 but by no more than Original Medicare's Part B Premium for 2024.	
Medical deductible	$400 combined The following services listed are excluded from the combined in-network and out-of-network deductible: In-Network only: Ambulance Services Chemotherapy Drugs and Administration Diabetic Monitoring Supplies Diagnostic Colonoscopy Diagnostic Mammography Lab Services Medicare Part B Covered Drugs Primary Care Physician's Office Specialist's Office Both In-Network and Out-of-Network: Emergency Room Services Medicare Covered Preventive Services (including Immunizations (Flu & Pneumonia)) Services not covered by Original Medicare Urgently Needed Services at Urgent Care Centers	$0

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Annual out-of-pocket maximum	$8,300 in-network $12,450 combined in and out-of-network		$8,300 in-network $12,450 combined in and out-of-network If you are eligible for Medicare cost-sharing assistance under your state's Medicaid program, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

	In-Network With Medicare only	**Out-of-Network With Medicare only**	**In-Network With Medicare & State Cost-Share Protection**
Doctor Office Visits			
Primary care provider (PCP)	$0 copay	50% of the cost	$0 copay
Specialist	$45 copay	50% of the cost	$0 copay
Preventive Care			
Including: Medicare covered screenings	Covered at no cost when you see an in-network provider	Preventive screenings may have a cost share when you see an out-of-network provider.	$0 copay
Telehealth Services (in addition to Original Medicare)			
Primary care provider (PCP)	$0 copay	Not covered	$0 copay
Specialist	$45 copay	Not covered	$0 copay
Urgent care services	$50 copay	Not covered	$0 copay
Substance abuse or behavioral health services	$0 copay	Not covered	$0 copay
Inpatient Care			
Acute inpatient hospital care	$335 copay per day for days 1-6 $0 copay per day for days 7-90	50% of the cost	$0 copay
Lab Services			
Lab tests from lab facility	$0 copay	50% of the cost	$0 copay

Lab Services (continued)			
Lab tests from outpatient hospital facility	$0 copay	50% of the cost	$0 copay
Outpatient Care			
Outpatient surgery at ambulatory surgical center	$325 copay	50% of the cost	$0 copay
Physical therapy at therapy facility	$25 copay	50% of the cost	$0 copay
X-rays at outpatient hospital facility	$125 copay	50% of the cost	$0 copay
Diagnostic testing at outpatient hospital facility	$95 copay	50% of the cost	$0 copay
Mental Health Services			
Inpatient psychiatric hospital Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	$335 copay per day for days 1-5 $0 copay per day for days 6-90	50% of the cost	$0 copay
Specialist's office	$45 copay	50% of the cost	$0 copay
Outpatient hospital	$100 copay	50% of the cost	$0 copay
Partial hospitalization	$70 copay	50% of the cost	$0 copay
Emergency Services			
Urgently needed services at an urgent care center	$50 copay	$50 copay	$0 copay
Ambulance services	$300 copay per date of service	$300 copay per date of service	$0 copay
Emergency room	$100 copay	$100 copay	$0 copay

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Additional Benefits & Programs	
Mandatory supplemental dental benefit DEN350	Included - cost share may apply. Please refer to the Summary of Benefits for additional details.
Mandatory supplemental vision benefit VIS751	Included - cost share may apply. Please refer to the Summary of Benefits for additional details.
Mandatory supplemental hearing benefit HER937	Included - cost share may apply. Please refer to the Summary of Benefits for additional details.
NationsMarket® Fresh, Prepared meal program	Included
SilverSneakers® fitness program	Included

2024 **Prescription Drug Benefits** at a Glance

HumanaChoice H5216-308 (PPO) Delaware, Virginia

Plan Highlights	
$0 copays	**$0** copays at select pharmacy locations and tiers. Additional details below.
Deductible	**$0** Deductible
Insulin costs	You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by your plan
Additional gap coverage	Additional gap coverage for the following: Insulin
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

Deductible

This plan has a **$0** deductible.

Initial Coverage

You pay the following until your total yearly drug costs for covered drugs reach **$5,030**. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.

Pharmacy Cost-Sharing

Get more value with cost-share options in bold	**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**	**90-day***	**30-day**	**90-day***	**30-day**	**90-day***
Tier 1: Preferred Generic	$0	$0	$10	$30	$0	**$0**
Tier 2: Generic	$0	$0	$20	$60	$0	**$0**
Tier 3: Preferred Brand	$47	$141	$47	$141	$47	**$131**
Tier 4: Non-Preferred Drug	$99	$297	$100	$300	$99	**$287**
Tier 5: Specialty Tier	33%	N/A	33%	N/A	33%	N/A

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

*Some drugs are limited to a 30-day supply.

Once your total yearly drug costs—what is paid both by you and our plan—reach **$5,030**, the costs of your drugs may go up. Please refer to the Summary of Benefits for more information.

You can get more out of your plan by doing the following:
- **Stay in–network.** You may pay less for your drugs at in-network pharmacies.
- **Consider using your preferred mail order cost–sharing pharmacies.** They typically offer a lower cost-share than standard mail order cost-sharing pharmacies for most drugs (your cost-share for specialty drugs is the same at any in-network pharmacy).
- **Get a 90-day supply of many of the drugs you take all of the time**. You'll get more and may pay less, especially when you fill at a preferred cost-sharing mail order pharmacy.

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.

"Extra Help"

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

Prior to reaching your annual **$8,000** out-of-pocket limit you will pay one of the following depending on your level of "Extra Help:"

- **$4.50** for generic/preferred multi-source drug or biosimilar; **$11.20** for any other drug; OR
- **$1.55** for generic/preferred multi-source drug or biosimilar; **$4.60** for any other drug; OR
- **$0** for all drugs

After reaching your annual **$8,000** 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.

If you have questions and are a Humana member, please contact Customer Care at 1-800-457-4708 (TTY: 711).

If you are not currently a Humana member, please contact a licensed Humana sales agent at 1-844-775-9622 (TTY: 711), 8 a.m. to 8 p.m. seven days a week from Oct. 1, 2023 – Mar. 31, 2024 and Monday - Friday the rest of the year.

Humana is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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

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

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.

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

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Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities.

- The following department has been designated to handle inquiries regarding Humana's non-discrimination policies: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235** (**TTY: 711)**.

Auxiliary aids and services, free of charge, are available to you. 877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

This information is available for free in other languages. Please call our customer service number at 877-320-1235 (TTY: 711). Hours of operation: 8 a.m. – 8 p.m. Eastern time.

Español (Spanish): Llame al número indicado para recibir servicios gratuitos de asistencia lingüística. **877-320-1235 (TTY: 711)**. Horas de operación: 8 a.m. a 8 p.m. hora del este.

繁體中文 (Chinese): 本資訊也有其他語言版本可供免費索取。請致電客戶服務部：**877-320-1235（聽障專線：711）**。辦公時間：東部時間上午 8 時至晚上 8 時。

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