

# Summary of Benefits

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## **Humana Premier Rx Plan (PDP) S5884-153**

State of Virginia

Our service area includes the following state(s): Virginia.

## 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 **1-800-706-0872 (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 **1-800-706-0872 (TTY: 711)** to view a copy of the EOC.
- 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 to make sure your drugs are covered.

### Understanding Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025.
- Effect on Current Coverage.** If you are currently enrolled in a Medicare Prescription Drug plan, your current Medicare Prescription Drug healthcare coverage will end once your new Medicare Prescription Drug coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Prescription Drug coverage starts. Please contact Tricare for more information.



# Let's talk about Humana Premier Rx Plan (PDP)

Find out more about the Humana Premier Rx Plan (PDP) - including the drug services it covers - in this easy-to-use guide.

Humana Premier Rx Plan (PDP) is a stand-alone prescription drug plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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

## To be eligible

To join Humana Premier Rx Plan (PDP), you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B and live in our service area.

## Plan name:

Humana Premier Rx Plan (PDP)

## How to reach us:

If you're a member of this plan, call toll-free: **1-800-281-6918 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-706-0872 (TTY: 711)**.

## October 1 - March 31:

Call 7 days a week from 8 a.m. - 8 p.m.

## April 1 - September 30:

Call Monday - Friday, 8 a.m. - 8 p.m.

Or visit our website:

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

## More about Humana Premier Rx Plan (PDP)

Do you have Medicare and Medicaid? If you are a dual-eligible beneficiary enrolled in both Medicare and the state's program, your prescription drug costs may be lower.

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.

Humana Premier Rx Plan (PDP) offers a pharmacy network with preferred cost sharing at select pharmacies. You may pay more at other pharmacies.



## A healthy partnership

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

**Humana.**



## Monthly Premium, Deductible and Limits

### Monthly Plan Premium

**\$100.10**

If you receive premium assistance, your plan premium may be reduced.

If you have Part B, you must keep paying your Medicare Part B premium.

### Pharmacy (Part D) deductible

**\$0** deductible on Tier 1, Tier 2 and Tier 6

**\$300** for Tier 3, Tier 4, Tier 5



## Prescription Drug Benefits

### PLAN HIGHLIGHTS

#### \$0 copays

**\$0** copays at select pharmacy locations and tiers. Additional details below.

#### Deductible

**\$0** deductible on Tier 1, Tier 2 and Tier 6

#### 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:  
Tier 1 drugs  
Tier 2 drugs  
Tier 6 drugs  
Insulin

#### Excluded drug coverage

Additional drug coverage for the following:  
Erectile dysfunction (ED) drugs

#### \$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 6. This plan has a **\$300** deductible for Tier 3, Tier 4, Tier 5 drugs. You pay the full cost of these drugs until you reach **\$300**. Then, you only pay your cost-share.

### INITIAL COVERAGE

You pay the following until your total yearly 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.

**Mail Order Cost-Sharing**

|                                   | Standard Mail Order Cost-Sharing |         | Preferred Mail Order Cost-Sharing<br>CenterWell Pharmacy™ |         |
|-----------------------------------|----------------------------------|---------|---|---------|
|                                   | 30-day                           | 90-day* | 30-day  | 90-day* |
| <b>Day Supply</b>                 |                                  |         |   |         |
| <b>Tier 1:</b> Preferred Generic  | \$5                              | \$15    | \$1   | \$0     |
| <b>Tier 2:</b> Generic            | \$10                             | \$30    | \$4   | \$0     |
| <b>Tier 3:</b> Preferred Brand    | \$47                             | \$141   | \$45  | \$125   |
| <b>Tier 4:</b> Non-Preferred Drug | 50%                              | 50%     | 49%   | 49%     |
| <b>Tier 5:</b> Specialty Tier     | 28%                              | N/A     | 28%   | N/A     |
| <b>Tier 6:</b> Select Care Drugs  | \$11                             | \$33    | \$0   | \$0     |

**Retail Cost-Sharing**

|                                   | Standard Retail Cost-Sharing |         | Preferred Retail Cost-Sharing |         |
|-----------------------------------|------------------------------|---------|-------------------------------|---------|
|                                   | 30-day                       | 90-day* | 30-day                        | 90-day* |
| <b>Day Supply</b>                 |                              |         |                               |         |
| <b>Tier 1:</b> Preferred Generic  | \$5                          | \$15    | \$1                           | \$3     |
| <b>Tier 2:</b> Generic            | \$10                         | \$30    | \$4                           | \$12    |
| <b>Tier 3:</b> Preferred Brand    | \$47                         | \$141   | \$45                          | \$135   |
| <b>Tier 4:</b> Non-Preferred Drug | 50%                          | 50%     | 49%                           | 49%     |
| <b>Tier 5:</b> Specialty Tier     | 28%                          | N/A     | 28%                           | N/A     |
| <b>Tier 6:</b> Select Care Drugs  | \$11                         | \$33    | \$0                           | \$0     |

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

\*Some drugs are limited to a 30-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 Mail Order Cost-Sharing**

|                                | Standard Mail Order Cost-Sharing |         | Preferred Mail Order Cost-Sharing<br>CenterWell Pharmacy™ |         |
|--------------------------------|----------------------------------|---------|---|---------|
|                                | 30-day                           | 90-day* | 30-day  | 90-day* |
| <b>Day Supply</b>              |                                  |         |   |         |
| <b>Tier 3:</b> Preferred Brand | \$25                             | \$75    | \$20  | \$50    |
| <b>Tier 5:</b> Specialty Tier  | \$35                             | N/A     | \$35  | N/A     |

## Insulin Retail Cost-Sharing

| Day Supply                     | Standard Retail Cost-Sharing |         | Preferred Retail Cost-Sharing |         |
|--------------------------------|------------------------------|---------|-------------------------------|---------|
|                                | 30-day                       | 90-day* | 30-day                        | 90-day* |
| <b>Tier 3:</b> Preferred Brand | \$25                         | \$75    | \$20                          | \$60    |
| <b>Tier 5:</b> Specialty Tier  | \$35                         | N/A     | \$35                          | N/A     |

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

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

## COVERAGE GAP

After you enter the coverage gap, you pay **25 percent** of the plan's cost for covered brand name drugs and **25 percent** of the plan's cost for covered generic drugs until your out-of-pocket costs total **\$8,000** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, **you may pay even less** for the following:

**Tier 1** (Preferred Generic) - All Drugs

**Tier 2** (Generic) - All Drugs

**Tier 3** (Preferred Brand) - Insulin

**Tier 5** (Specialty Tier) - Insulin

**Tier 6** (Select Care Drugs) - All Drugs

For more information on cost sharing in the coverage gap, please call us or access your Evidence of Coverage online.

## CATASTROPHIC COVERAGE

After your yearly out-of-pocket drug costs reach **\$8,000** you pay **\$0** for plan-covered Part D and Excluded drugs.

## EXCLUDED DRUG COVERAGE

**Erectile dysfunction (ED) drugs** Covered at Tier 2 cost-share amount.

**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.

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 1-800-772-1213 Monday — Friday, 7 a.m. — 7 p.m. TTY users should call 1-800-325-0778. 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 a standard 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.





# Notes

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## Important

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### At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable federal civil rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:  
Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.  
If you need help filing a grievance, call **1-877-320-1235** or if you use a TTY, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

### Auxiliary aids and services, free of charge, are available to you. **1-877-320-1235 (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.

## Multi-Language Insert

### Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-320-1235 (TTY: 711). Someone who speaks English can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-320-1235 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235 (听障专线：711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-320-1235 (聽障專線：711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Form CMS-10802 (Expires 12/31/25)

Form Approved OMB# 0938-1421

**Humana.**

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بخططنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY: 711) 1-877-320-1235. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-320-1235 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-320-1235 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

**Japanese:** 当社の健康保険と処方薬プランに関するご質問にお答えするために、無料の通訳サービスをご用意しています。通訳をご用命になるには、1-877-320-1235 (TTY:711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。



## Find out **more**

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You can see our plan's **pharmacy directory** at our website at **[humana.com/finder/pharmacy/](http://humana.com/finder/pharmacy/)** or call us at the number listed at the beginning of this booklet and we will send you one.



You can see our plan's **drug guide** at our website at **[humana.com/medicaredruglist](http://humana.com/medicaredruglist)** or call us at the number listed at the beginning of this booklet and we will send you one.

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.

The Humana Premier Rx Plan (PDP) Prescription Drug Plan pharmacy network includes limited lower-cost, preferred pharmacies in urban areas of AR, CT, DE, IA, IN, KY, MA, ME, MI, MN, MO, MS, NC, ND, NJ, NY, OH, PR, RI, SD, TN, WI, WV; suburban areas of CT, DE, MA, MI, MN, MT, ND, NJ, NY, OH, PA, PR, RI, WV; and rural areas of IA, MN, MT, ND, NE, SD, VT, WY. There are an extremely limited number of preferred cost share pharmacies in urban areas in the following states: DE, ME, MI, MN, MS, ND, OH; suburban areas of MT and ND; and rural areas of ND. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call Customer Care at 1-800-281-6918 (TTY: 711) or consult the online pharmacy directory at **[Humana.com/PlanDocuments](http://Humana.com/PlanDocuments)**.

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## **The information you need is just a click away.**

Visit [Humana.com/PlanDocuments](https://www.humana.com/PlanDocuments) to check details about your plan, including benefits and costs.

If you'd like a printed Evidence of Coverage, Provider Directory, or Drug List mailed to you, you can request one online at the website above, or call **1-800-281-6918 (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 List" or "Provider Directory."

## **Activate your secure MyHumana account.**

Your online MyHumana account is an important part of your Humana membership. Use it to view your plan 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/MyHumanaPlan](https://www.humana.com/MyHumanaPlan) 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 those future calls by calling the Customer Care number on the back of your ID card.

**Humana Inc.**

P.O. Box 14168

Lexington, KY 40512-4168

Important information about your plan

**Humana.com**