2018

Summary of Benefits

Humana Value Plus H5619-037 (HMO)

Southern California
Select Counties in California

Our service area includes the following county/counties in California: Los Angeles, Orange, Riverside, San Bernardino, San Diego.

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Let's talk about **Humana Value Plus H5619-037 (HMO)**

Find out more about the Humana Value Plus H5619-037 (HMO) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Value Plus H5619-037 (HMO) is a Medicare Advantage HMO 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, ask us for the "Evidence of Coverage" or you will receive one after you enroll.

To be eligible

To join Humana Value Plus H5619-037 (HMO), 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 H5619-037 (HMO)

How to reach us:

If you're a member of this plan, call toll-free: **1-800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-833-2364 (TTY: 711)**.

October 1 - February 14:
Call 7 days a week from 8 a.m. - 8 p.m.

February 15 - September 30:
Call Monday - Friday, 8 a.m. - 8 p.m.

Or visit our website:
Humana.com/medicare.

As a member you must select an in-network doctor to act as your Primary Care Provider (PCP). Humana Value Plus H5619-037 (HMO) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services.

A healthy partnership

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

This document is available in other formats such as Braille and large print.
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Póngase en contacto con un agente de ventas certificado de Humana al 1-800-833-2364 (TTY: 711).

Monthly Premium, Deductible and Limits

Monthly premium	**$16.30** You must keep paying your Medicare Part B premium.
Medical deductible	**$183** in-network Part B deductible Services not covered by Original Medicare, Part A services (IP, Skilled Nursing and Home Health), Medicare covered preventive services, Ambulance and Emergency Room services, Urgently Needed Services at Urgent Care Centers, Diabetic Monitoring Supplies and Part B Drugs from a Network Retail Pharmacy do not apply to the in-network Part B deductible.
Pharmacy (Part D) deductible	**$405** only applies to Tier 3,Tier 4,Tier 5.
Maximum out-of-pocket responsibility	**$6,700** in-network The most you pay for copays, coinsurance and other costs for medical services for the year.

Covered Medical and Hospital Benefits

Acute inpatient hospital care	**$480** copay per day for days 1-3 **$0** copay per day for days 4-90 Your plan covers an unlimited number of days for an inpatient stay.
Outpatient hospital coverage	• Surgery Services at Outpatient Hospital **20%** of the cost • Surgery Services at Ambulatory Surgical Center **20%** of the cost
Doctor visits	• Primary care provider: **$0** copay • Specialist: **$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." Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a referral and/or prior authorization from the plan.

Preventive care	**Our plan covers many preventive services at no cost when you see an in-network provider, including:** • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including flu shots, hepatitis B shots, pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Annual Wellness Visit • Lung cancer screening • Routine physical exam **Any additional preventive services approved by Medicare during the contract year will be covered.**
EMERGENCY CARE	
Emergency room	**$80** copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.
Urgently needed services	**20%** of the cost at an urgent care center Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.
OUTPATIENT CARE AND SERVICES	
Diagnostic services, labs and imaging Cost share may vary depending on the service and where service is provided	• Diagnostic mammography: **20%** of the cost • Diagnostic radiology: **$0** or **20%** of the cost • Lab services: **$0** or **20%** of the cost • Diagnostic tests and procedures: **$0** or **20%** of the cost • Outpatient X-rays: **$0** or **20%** of the cost • Radiation therapy: **20%** of the cost

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Covered Medical and Hospital Benefits (cont.)

Hearing	Medicare covered hearing exam: **$0** copay **Routine hearing:** • **$0** copayment for fitting/evaluation, routine hearing exam up to 1 per year. • **$1000** maximum benefit coverage amount for hearing aids (all types) up to 1 every 3 years.
Dental	Medicare covered dental services: **$0** copay **Routine dental:** • **$0** copayment for bitewing x-rays up to 1 set(s) per year. • **$0** copayment for amalgam filling, composite filling, denture reline, extractions, periodic oral exam or comprehensive oral evaluation, prophylaxis (cleaning) up to 1 per year. • **$0** copayment for necessary anesthesia with covered service up to unlimited per year.
Vision	• Medicare-covered vision services: **$0** copay • Diabetic eye exam: **$0** copay • Glaucoma screening: **$0** copay • Eyewear (post-cataract): **20%** of the cost **Routine vision:** • **$0** copayment for routine exam, refraction up to 1 per year. • **$200** maximum benefit coverage amount per year for contact lenses or eyeglasses - lenses and frames (includes fitting). Eyeglasses include ultraviolet protection and scratch resistant coating.
Mental health services	**Inpatient:** • **$480** copay per day for days 1-3 • **$0** copay per day for days 4-90 • Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. **Outpatient** (group and individual therapy visits): **20%** of the cost
Skilled nursing facility (SNF)	• **$0** copay per day for days 1-20 • **$167.50** copay per day for days 21-100 • Your plan covers up to 100 days in a SNF
Physical Therapy Cost share may vary depending on the service and where service is provided.	• **$0** or **20%** of the cost
ADDITIONAL BENEFITS	
Ambulance (ground)	**20%** of the cost
Transportation	**$0** copay for up to 36 one-way trips to plan approved locations. Not to exceed 50 miles per trip.

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Prescription Drug Benefits

Medicare Part B drugs

- Chemotherapy drugs: **13%** of the cost
- Other Part B drugs: **$0** or **13%** of the cost

Cost share depends on where service is provided. Contact us for more details.

PRESCRIPTION DRUGS

Pharmacy (Part D) Deductible
$405 only applies to Tier 3,Tier 4,Tier 5.

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach $3,750. Total yearly drug costs are the total drug costs paid by both you and our plan.

	Preferred Retail Pharmacy	Standard Retail Pharmacy	Preferred Mail Order	Standard Mail Order
30-day supply				
Tier 1: Preferred Generic	**$0** copay	**$10** copay	**$0** copay	**$10** copay
Tier 2: Generic	**$19** copay	**$20** copay	**$19** copay	**$20** copay
Tier 3: Preferred Brand	**$47** copay	**$47** copay	**$47** copay	**$47** copay
Tier 4: Non-Preferred Drug	**$100** copay	**$100** copay	**$100** copay	**$100** copay
Tier 5: Specialty	**25%** of the cost	**25%** of the cost	**25%** of the cost	**25%** of the cost
90-day supply				
Tier 1: Preferred Generic	**$0** copay	**$30** copay	**$0** copay	**$30** copay
Tier 2: Generic	**$57** copay	**$60** copay	**$0** copay	**$60** copay
Tier 3: Preferred Brand	**$141** copay	**$141** copay	**$131** copay	**$141** copay
Tier 4: Non-Preferred Drug	**$300** copay	**$300** copay	**$290** copay	**$300** copay

Specialty drugs are limited to a 30 day supply.

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 the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our "Evidence of Coverage" online.

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

You may get drugs from an out-of-network pharmacy but may pay more than you pay at an in-network pharmacy.

Days' Supply Available
Unless otherwise specified, you can get your Part D medicine in the following days' supply amounts:

- One month supply (up to 30 days)*
- Two month supply (31-60 days)
- Three month supply (61-90 days)

*Long term care pharmacy (one month supply = 31 days)

Coverage Gap

After you enter the coverage gap, you pay **35 percent** of the plan's cost for covered brand name drugs and **44 percent** of the plan's cost for covered generic drugs until your costs total **$5,000** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$5,000**, you pay the greater of:

- **5%** of the cost, or
- **$3.35** copay for generic (including brand drugs treated as generic) and a **$8.35** copayment for all other drugs

Additional benefits

Medicare covered foot care (podiatry)	**$0** copay
Medical equipment/ supplies	• Durable medical equipment (like wheelchairs or oxygen): **11%** of the cost • Medical supplies: **13%** of the cost • Prosthetics (artificial limbs or braces): **13%** of the cost • Diabetic monitoring supplies: **$0** copay
Rehabilitation services Cost share may vary depending on the service and where service is provided.	• Physical, occupational and speech therapy: **$0** or **20%** of the cost • Cardiac rehabilitation: **$0** or **20%** of the cost • Pulmonary rehabilitation: **$0** or **20%** of the cost

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

Chiropractic services
Medicare-covered Chiropractic Services:
- **$0** copay

Routine Chiropractic Services:
- **$0** copay per visit for up to 12 visits copay

Routine foot care
$0 copay per visit for up to 12 visits in network

Meals
Well Dine Meal Program - Humana's meal program for members following an inpatient stay in the hospital or nursing facility

HumanaFirst nurse advice line
Health advice from a registered nurse, available 24 hours a day, seven days a week.

Over-the-counter (OTC) allowance
Up to **$50** every 3 months for the purchase of OTC supplies from Humana Pharmacy mail delivery.

Go365™ by Humana
Rewards for completing preventive health screenings and health and wellness activities.

Fitness benefit
SilverSneakers® Fitness Program – Basic fitness center membership including fitness classes.

Find out **more**

You can see our plan's **provider and pharmacy directory** at our website at **www.humana.com/members/tools** 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 formulary** at our website at **www.humana.com/medicare/medicare_prescription_drugs/medicare_drug_tools/medicare_drug_list/** or call us at the number listed at the beginning of this booklet and we will send you one.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

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 provider/pharmacy network may change at any time. You will receive notice when necessary.

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Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- 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.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-800-281-6918 or if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512 - 4618

If you need help filing a grievance, call 1-800-281-6918 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 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, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-800-281-6918 (TTY: 711)**.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-281-6918 (TTY: 711)**.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-281-6918 (TTY: 711)**。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-281-6918 (TTY: 711)**.

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . **1-800-281-6918 (TTY: 711)** 번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-281-6918 (TTY: 711)**.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-281-6918 (телетайп: 711)**.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-281-6918 (TTY: 711)**.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-281-6918 (ATS : 711)**.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-800-281-6918 (TTY: 711)**.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-281-6918 (TTY: 711)**.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-281-6918 (TTY: 711)**.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-281-6918 (TTY: 711)**.

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-281-6918 (TTY：711)** まで、お電話にてご連絡ください。

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-281-6918 (TTY: 711)** تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-281-6918 (TTY: 711)**.

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-281-6918** (هاتف الصُم: **711**).

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