2019 **Health Plan Benefits** at a Glance

Humana Value Plus™ H5216-197 (PPO) Arizona

Plan Costs	With Medicare only	Out-of-Network	With Medicare & State Cost-Share Protection
Monthly plan premium	$21.30		$0
Part B deductible (exclusions apply*)	$183 combined	$183 combined	$0
Annual out-of-pocket maximum	$6,700	$10,000 combined	$0
Doctor Office Visits			
Primary care provider (PCP)	$0 copay	$0 copay	$0 copay
Specialist	20% of the cost	20% of the cost	$0 copay
Preventive Care			
Including: Medicare covered screenings	Covered at no cost when you see an in-network provider	Cost-sharing may apply for out-of-network providers	$0 copay
Inpatient Care			
Acute inpatient hospital care	$1,750 per admit	$1,750 per admit	$0 deductible $0 copay per day for days 1-60 $0 copay per day for days 61-90 $0 copay per day for days 91-150
Lab Services			
Lab tests from lab facility	$0 copay	$0 copay	$0 copay
Lab tests from outpatient hospital facility	20% of the cost	20% of the cost	$0 copay
Outpatient Care			
Outpatient surgery at ambulatory surgical center	20% of the cost	20% of the cost	$0 copay
Physical therapy at therapy facility	20% of the cost	20% of the cost	$0 copay
X-rays at outpatient hospital facility	20% of the cost	20% of the cost	$0 copay
Diagnostic testing at outpatient hospital facility	20% of the cost	20% of the cost	$0 copay

Continued:

Emergency Services			
Urgently needed services at an urgent care center	20% of the cost	20% of the cost	$0 copay
Ground ambulance services	20% of the cost	20% of the cost	$0 copay
Emergency room	$90 copay	$90 copay	$0 copay

Additional Benefits & Programs	
Go365™ by Humana	Rewards for completing preventive health screenings/activities
Virtual Visits	Included - cost share may apply. Please refer to the Summary of Benefits for additional details
Over-the-Counter (OTC) mail order	$0 copay; up to $220 every 3 months
Routine dental services DEN133	Included - cost share may apply. Please refer to the Summary of Benefits for additional details
Routine vision services VIS752	Included - cost share may apply. Please refer to the Summary of Benefits for additional details
Transportation services	$0 for up to 24 one-way trips to plan approved locations. Not to exceed 50 miles per trip.
SilverSneakers® fitness program	Included
Routine hearing services HER953	Included - cost share may apply. Please refer to the Summary of Benefits for additional details

2019 **Prescription Drug Benefits** at a Glance

Humana Value Plus™ H5216-197 (PPO) Arizona

If you don't receive Extra Help for your drugs, you'll pay the following:

Deductible This plan has a **$415** deductible for Tier 2,Tier 3,Tier 4,Tier 5 drugs. You pay the full cost of these drugs until you reach $415. Then, you only pay your cost-share.

Initial Coverage In this stage, you may pay a cost-share that is either a **copay** — a set dollar amount — or **coinsurance** — a set percentage amount you pay each time you fill your drug.

Preferred cost-sharing

Pharmacy options Your lowest cost-share options are in bold	**Retail** To find the preferred cost-share retail pharmacies near you, go to **Humana.com/pharmacyfinder**		**Mail Order** Humana Pharmacy®	
	30-day supply	**90-day supply***	**30-day supply**	**90-day supply***
Tier 1: Preferred Generic	$1	$3	$1	**$0**
Tier 2: Generic	$20	$60	$20	**$0**
Tier 3: Preferred Brand	$47	$141	$47	**$131**
Tier 4: Non-Preferred Drug	50%	**50%**	50%	**50%**
Tier 5: Specialty Tier	25%	N/A	25%	N/A

Standard cost-sharing

Pharmacy options	**Retail** All other network retail pharmacies.		**Mail Order** Walmart Mail	
	30-day supply	**90-day supply***	**30-day supply**	**90-day supply***
Tier 1: Preferred Generic	$10	$30	$10	$30
Tier 2: Generic	$20	$60	$20	$60
Tier 3: Preferred Brand	$47	$141	$47	$141
Tier 4: Non-Preferred Drug	50%	**50%**	50%	**50%**
Tier 5: Specialty Tier	25%	N/A	25%	N/A

Once your total yearly drug cost—what is paid both by you and our plan—reach **$3,820,** 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'll pay less for your drugs at in-network pharmacies.
- **Use preferred cost–sharing pharmacies.** They offer a lower cost-share than standard 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.

Continued:

If you receive Extra Help for your drugs, you'll pay the following:

Deductible You may pay **$0** or **$85** depending on the level of Extra Help you receive. If your deductible is $85, you pay the full cost of your drugs until you meet your deductible. Then, you only pay your cost-share.

Pharmacy cost-sharing		
For generic drugs (including brand drugs treated as generic), either:	**30-day supply** $0 copay; or $1.25 copay; or $3.40 copay; or 15% of the cost	**90-day supply** $0 copay; or $1.25 copay; or $3.40 copay; or 15% of the cost
For all other drugs, either:	$0 copay; or $3.80 copay; or $8.50 copay; or 15% of the cost	$0 copay; or $3.80 copay; or $8.50 copay; or 15% of the cost

Other pharmacies are available in our network. *Some drugs are limited to a 30-day supply.

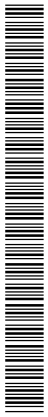
*Services not covered by Original Medicare, Part A services (IP, Skilled Nursing and Home Health), Medicare covered preventive services, Ambulance and Emergency Room services, Urgently Needed Services at Urgent Care Centers, Diabetic Monitoring Supplies and Part B Drugs from a Network Retail Pharmacy do not apply to the in-network and out-of network Part B deductible.

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. - 8 p.m. seven days a week from Oct. 1, 2018 - Mar. 31, 2019 and Monday through 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. This information is not a complete description of benefits. Call 1-800-457-4708 (TTY: 711) for more information.

Limitations on healthcare and prescription services delivered via virtual visits and communications options vary by state. Virtual visit services are not a substitute for emergency care and not intended to replace your primary care provider or other providers in your network. This material is provided for informational use only and should not be construed as medical advice or used in place of consulting a licensed medical professional.

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.



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If you need these services, call **1-877-320-1235** 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, sex, sexual orientation, gender identity, or religion, you can file a grievance with Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.

If you need help filing a grievance, call **1-877-320-1235** 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 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, DC 20201,

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Multi-Language Interpreter Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-877-320-1235 **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-1235 **(TTY: 711)** 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 1-877-320-1235 **(TTY : 711)**。 ... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-320-1235 **(TTY: 711)**.... 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-877-320-1235 **(TTY: 711)** 번으로 전화해 주십시오 .... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-320-1235 **(TTY: 711)**.... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-320-1235 **(телетайп: 711)**.... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-320-1235 **(TTY: 711)**.... ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-320-1235 **(ATS: 711)**.... UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-320-1235 **(TTY: 711)**.... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-320-1235 **(TTY: 711)**.... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-320-1235 **(TTY: 711)**.... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-320-1235 **(TTY: 711)**.... 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。 1-877-320-1235 **(TTY: 711)** まで、お電話にてご連絡ください。...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-320-1235 تماس بگیرید. **(TTY: 711)**

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 1-877-320-1235 **(TTY: 711)**....

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-320-1235 **(رقم هاتف الصم والبكم: 711)**.