2022 Health Plan Benefits at a Glance

HumanaChoice H5216-237 (PPO) Upstate South Carolina

Plan Costs	With Medicare only In-Network	With Medicare only Out-of-Network	With Medicare Cost-Share Protection
Monthly plan premium	$44		If you receive premium assistance, your plan premium may be reduced.
Medical deductible		$1,000 combined All services received from in-network providers do not apply to the combined in-network and out-of-network deductible. Services not covered by Original Medicare, Ambulance services, Emergency room services, Urgently Needed Services at Urgent Care Centers, Immunizations (Flu & Pneumonia), and COVID-19 Tests and Treatment received from out-of-network providers do not apply to the combined in-network and out-of-network deductible.	$0
Annual out-of-pocket maximum	$6,700	$10,000 combined	$0
Doctor Office Visits			
Primary care provider (PCP)	$15 copay	40% of the cost	$0 copay
Specialist	$50 copay	40% 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

Continued:

Telehealth Services (in addition to Original Medicare)			
Primary care provider (PCP)	$0 copay	Not covered	$0 copay
Specialist	$50 copay	Not covered	$0 copay
Urgent care services	$0 copay	Not covered	$0 copay
Substance abuse or behavioral health services	$0 copay	Not covered	$0 copay
Inpatient Care			
Acute inpatient hospital care	$390 copay per day for days 1-5 $0 copay per day for days 6-90	40% of the cost	$0 deductible $0 copay per day for days 1-150
Lab Services			
Lab tests from lab facility	$0 copay	40% of the cost	$0 copay
Lab tests from outpatient hospital facility	$45 copay	40% of the cost	$0 copay
Outpatient Care			
Outpatient surgery at ambulatory surgical center	$345 copay	40% of the cost	$0 copay
Physical therapy at therapy facility	$25 copay	40% of the cost	$0 copay
X-rays at outpatient hospital facility	$100 copay	40% of the cost	$0 copay
Diagnostic testing at outpatient hospital facility	$100 copay	40% 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.	$587 copay per day for days 1-3 $0 copay per day for days 4-90	50% of the cost	$0 deductible $0 copay per day for days 1-190
Specialist's office	$40 copay	40% of the cost	$0 copay
Outpatient hospital	$100 copay	40% of the cost	$0 copay

Mental Health Services (continued)			
Partial hospitalization	$55 copay	40% of the cost	$0 copay
Emergency Services			
Urgently needed services at an urgent care center	$50 copay	40% of the cost	$0 copay
Ambulance services	$270 copay per date of service	$270 copay per date of service	$0 copay
Emergency room	$90 copay	$90 copay	$0 copay

Additional Benefits & Programs	
Routine vision services VIS751	Included - cost share may apply. Please refer to the Summary of Benefits for additional details.
Transportation services	**$0** copay for plan approved location up to 24 one-way trip(s) per year. This benefit is not to exceed 50 miles per trip.
Over-the-Counter (OTC) mail order	**$25** maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products.
SilverSneakers® fitness program	Included
Humana Well Dine® Meal Program	Included
Routine hearing services HER941	Included - cost share may apply. Please refer to the Summary of Benefits for additional details.
Wigs (related to chemotherapy treatment)	Included
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 AuthorbyHumana.com or contact Customer Care on the back of your ID card if you need help finding an in-network provider.

2022 Prescription Drug Benefits at a Glance

HumanaChoice H5216-237 (PPO) Upstate South Carolina

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

Deductible This plan has a **$250** deductible for Tier 3, Tier 4, Tier 5 drugs. You pay the full cost of these drugs until you reach $250. 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 **Get more value with cost-share options 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	$5	$15	$5	**$0**
Tier 2: Generic	$12	$36	$12	**$0**
Tier 3: Preferred Brand	$47	$141	$47	**$131**
Tier 4: Non-Preferred Drug	$100	$300	$100	**$290**
Tier 5: Specialty Tier	28%	N/A	28%	N/A

Standard cost-sharing

Pharmacy options	**Retail** All other network retail pharmacies.		**Mail Order** Walmart Mail, PillPack	
	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	$100	$300	$100	$300
Tier 5: Specialty Tier	28%	N/A	28%	N/A

Once your total yearly drug costs—what is paid both by you and our plan—reach **$4,430,** 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 **$99** depending on your level of Extra Help for Tier 3, Tier 4, Tier 5. If your deductible is **$99**, you pay the full cost of these drugs until you reach **$99**. Then, you only pay your cost-share.

Pharmacy cost-sharing		
	30-day supply	**90-day supply***
For generic drugs (including brand drugs treated as generic), either:	$0 copay; or $1.35 copay; or $3.95 copay; or 15% of the cost	$0 copay; or $1.35 copay; or $3.95 copay; or 15% of the cost
For all other drugs, either:	$0 copay; or $4 copay; or $9.85 copay; or 15% of the cost	$0 copay; or $4 copay; or $9.85 copay; or 15% of the cost

Other pharmacies are available in our network.

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

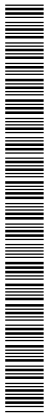
If you have questions and are a Humana member, please contact Customer Care at 1-833-502-2012 (TTY: 711). If you are not currently a Humana member, please contact a licensed Humana sales agent at 1-833-502-2012 (TTY: 711), 8 a.m. - 8 p.m. seven days a week from Oct. 1, 2021 - Mar. 31, 2022 and Monday 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.

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.

Get all your health plan details at AuthorbyHumana.com



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Important!

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, marital status or religion. 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 273, Sidney NE 69162.
  If you need help filing a grievance, call **1-833-502-2012** 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.

Language assistance services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę́ niká'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك