2023 **Health Plan Benefits** at a Glance

HumanaChoice H5525-042 (PPO) Ohio

Plan Costs	With Medicare Only	With Medicare & State Cost-Share Protection
Monthly plan premium	$0	$0
Annual out-of-pocket maximum	$7,550 in-network $7,550 combined out-of-network	$0

	With Medicare only In-Network	With Medicare only Out-of-Network	With Medicare & State Cost-Share Protection
Doctor Office Visits			
Primary care provider (PCP)	$20 copay	$20 copay	$0 copay
Specialist	$50 copay	$50 copay	$0 copay
Preventive Care			
Including: Medicare covered screenings	Covered at no cost when you see an in-network provider	Many preventive screenings covered at no cost when you see an in-network provider.	$0 copay
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	$490 copay per day for days 1-4 $0 copay per day for days 5-90	$490 copay per day for days 1-4 $0 copay per day for days 5-90	$0 copay
Lab Services			
Lab tests from lab facility	$0 copay	$0 copay	$0 copay

Continued:

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Lab Services (continued)			
Lab tests from outpatient hospital facility	$35 copay	$35 copay	$0 copay
Outpatient Care			
Outpatient surgery at ambulatory surgical center	$415 copay	$415 copay	$0 copay
Physical therapy at therapy facility	$10 copay	$10 copay	$0 copay
X-rays at outpatient hospital facility	$110 copay	$110 copay	$0 copay
Diagnostic testing at outpatient hospital facility	20% of the cost	20% 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.	$490 copay per day for days 1-3 $0 copay per day for days 4-90	$490 copay per day for days 1-3 $0 copay per day for days 4-90	$0 copay
Specialist's office	$40 copay	$40 copay	$0 copay
Outpatient hospital	$100 copay	$100 copay	$0 copay
Partial hospitalization	$55 copay	$55 copay	$0 copay
Emergency Services			
Urgently needed services at an urgent care center	20% of the cost	20% of the cost	$0 copay
Ambulance services	$290 copay per date of service	$290 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.		
Routine hearing services HER958	Included - cost share may apply. Please refer to the Summary of Benefits for additional details.		

2023 **Prescription Drug Benefits** at a Glance

HumanaChoice H5525-042 (PPO) Ohio

Important Message About What You Pay for Vaccines
Our plan covers most Part D vaccines at no cost to you, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Important Message About What You Pay for Insulin
You won't pay more than $35 for a one-month (up to 30-day) supply of each Part D insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible. This applies to all Part D covered insulins, including the Select Insulins covered under the Insulin Savings Program as described below. If you receive "Extra Help", you will still pay no more than $35 for a one-month supply for each Part D covered insulin. Please see your Prescription Drug Guide to find all Part D insulins covered by your plan.

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

Deductible No deductible for Tier 1 and Tier 2. 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 You pay the following until your total yearly drug costs reach **$4,660**. 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

Pharmacy options **Get more value with cost-share options in bold**	**Standard** Walmart Mail, PillPack Other pharmacies are available in our network. To find the pharmacy mail order options, go to **Humana.com/pharmacyfinder**		**Preferred** CenterWell Pharmacy™	
	30-day supply	**90-day supply***	**30-day supply**	**90-day supply***
Tier 1: Preferred Generic	$10	$30	$7	**$0**
Tier 2: Generic	$20	$60	$17	**$0**
Tier 3: Preferred Brand	$47	$141	$47	**$131**
Tier 4: Non-Preferred Drug	$100	$300	$100	**$290**
Tier 5: Specialty Tier	29%	N/A	29%	N/A

Retail Cost-Sharing

Pharmacy options	**Retail** All network retail pharmacies. To find the retail pharmacies near you, go to **Humana.com/pharmacyfinder**	
	30-day supply	**90-day supply***
Tier 1: Preferred Generic	$7	$21

Continued:

Tier 2: Generic	$17	$51
Tier 3: Preferred Brand	$47	$141
Tier 4: Non-Preferred Drug	$100	$300
Tier 5: Specialty Tier	29%	N/A

Once your total yearly drug costs—what is paid both by you and our plan—reach **$4,660** 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 your preferred mail order cost–sharing pharmacies.** They 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.

Insulin Savings Program
Your plan participates in the Insulin Savings Program. You will pay no more than $35 for a one-month (up to a 30-day) supply for Select Insulins, no matter what cost-sharing tier it's on, even if you haven't paid your deductible. To identify which Select Insulins are included within the Insulin Savings Program, look for the ***ISP*** indicator in your Prescription Drug Guide. Please refer to the Summary of Benefits for additional details.

Your plan also provides enhanced insulin coverage which means you will pay no more than $35 for a one-month (up to 30-day) supply for all Part D insulins covered by our plan, including Select Insulins, no matter what cost-sharing tier it's on, even if you haven't paid your deductible. The enhanced insulin coverage is available, even if you receive "Extra Help".

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

Deductible You may pay **$0** or **$104** depending on your level of "Extra Help" for Tier 3, Tier 4, Tier 5. If your deductible is **$104**, you pay the full cost of these drugs until you reach **$104**. Then, you only pay your cost-share.

Pharmacy cost-sharing		
For generic drugs (including brand drugs treated as generic), either:	**30-day supply**	**90-day supply***
	$0 copay; or $1.45 copay; or $4.15 copay; or 15% of the cost	$0 copay; or $1.45 copay; or $4.15 copay; or 15% of the cost
For all other drugs, either:	$0 copay; or $4.30 copay; or $10.35 copay; or 15% of the cost	$0 copay; or $4.30 copay; or $10.35 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 1-800-457-4708 (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, 2022 - Mar. 31, 2023 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
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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