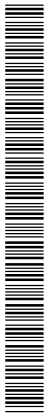
2019 **Health Plan Benefits** at a Glance

HumanaChoice® H5216-063 (PPO) Twin Cities

Plan Costs	In-Network	Out-of-Network
Monthly plan premium	$107	
Annual out-of-pocket maximum	$3,000	$4,500 combined
Doctor Office Visits		
Primary care provider (PCP)	$0 copay	20% of the cost
Specialist	$25 copay	20% of the cost
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
Inpatient Care		
Acute inpatient hospital care	$100 per admit	20% of the cost
Lab Services		
Lab tests from lab facility	$10 copay	20% of the cost
Lab tests from outpatient hospital facility	$10 copay	20% of the cost
Outpatient Care		
Outpatient surgery at ambulatory surgical center	$50 copay	20% of the cost
Physical therapy at therapy facility	$40 copay	20% of the cost
X-rays at outpatient hospital facility	$85 copay	20% of the cost
Diagnostic testing at outpatient hospital facility	$85 copay	20% of the cost
Emergency Services		
Urgently needed services at an urgent care center	$25 copay	20% of the cost
Ground ambulance services	$265 per date of service	$265 per date of service
Emergency room	$120 copay	$120 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 $75 every 3 months	
Routine dental services DEN982	Included - cost share may apply. Please refer to the Summary of Benefits for additional details	

Continued:

Additional Benefits & Programs (continued)	
Routine vision services VIS751	Included - cost share may apply. Please refer to the Summary of Benefits for additional details
Transportation services	$0 in-network for up to 12 one-way trips to plan approved locations. Not to exceed 25 miles per trip.
SilverSneakers® fitness program	Included
Routine hearing services HER941	Included - cost share may apply. Please refer to the Summary of Benefits for additional details



Humana.com

H5216063000BAG19

Humana®

2019 **Prescription Drug Benefits** at a Glance

HumanaChoice® H5216-063 (PPO) Twin Cities

Deductible This plan has a **$250** deductible for 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 **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	$0	**$0**	$0	**$0**
Tier 2: Generic	$6	$18	$6	**$0**
Tier 3: Preferred Brand	$47	$141	$47	**$131**
Tier 4: Non-Preferred Drug	50%	**50%**	50%	**50%**
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	
	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	28%	N/A	28%	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.

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

Continued:

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Routine dental DEN982 Use the HumanaDental Medicare network for the Mandatory Supplemental Dental. The provider locator can be found at Humana.com > Find a Doctor > from the Search Type drop down select Dental > under Coverage Type select All Dental Networks > enter zip code > from the network drop down select HumanaDental Medicare.	• **0%** coinsurance for bitewing (set), intraoral x-ray up to 1 per year • **0%** coinsurance for panoramic film or diagnostic x-ray up to 1 every 5 years • **0%** coinsurance for perio exam up to 1 every 3 years • **0%** coinsurance for periodic oral exam, emergency exam, and/or comprehensive oral eval, prophylaxis, fluoride up to 2 per year • **0%** coinsurance for anesthesia with covered service • **50%** coinsurance for recement up to 1 every 5 years • **50%** coinsurance for simple/surgical extractions, emergency pain treatment, amalgam and/or composite filling up to 2 per year • **70%** coinsurance for scaling/root planing up to 1 per quadrant every 3 years • **70%** coinsurance for denture adjustment, denture reline, root canal up to 1 per year • **70%** coinsurance for complete, partial dentures up to 1 set every 5 years • **70%** coinsurance for crown, perio maintenance, oral surgery up to 2 per year • **$2000** max benefit amount per year	• **50%** coinsurance for bitewing (set), intraoral x-ray up to 1 per year • **50%** coinsurance for panoramic film or diagnostic x-ray up to 1 every 5 years • **50%** coinsurance for perio exam up to 1 every 3 years • **50%** coinsurance for periodic oral exam, emergency exam, and/or comprehensive oral eval, prophylaxis, fluoride up to 2 per year. • **50%** coinsurance for anesthesia with covered service • **55%** coinsurance for recement up to 1 every 5 years • **55%** coinsurance for simple/surgical extractions, emergency pain treatment, amalgam and/or composite filling up to 2 per year • **75%** coinsurance for scaling/root planing up to 1 per quadrant every 3 years • **75%** coinsurance for denture adjustment, denture reline, root canal up to 1 per year • **75%** coinsurance for complete, partial dentures up to 1 set every 5 years • **75%** coinsurance for crown, perio maintenance, oral surgery up to 2 per year • **$2000** max benefit amount per year • Out-of-network benefits are subject to any in-network benefit maximum/limit/exclusion
VISION SERVICES		
Medicare covered vision services	**$25** copay	**20%** of the cost
Diabetic Eye Exam	**$0** copay	**20%** of the cost
Glaucoma screening	**$0** copay	**20%** of the cost

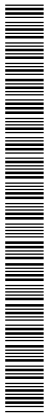
You do not need a referral to receive covered services from providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

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.



Humana.com

H5216063000BAG19

Humana®

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, sex, sexual orientation, gender identity, or religion. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion.

Humana Inc. and its subsidiaries provide: (1) 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; and, (2) 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 **1-877-320-1235** 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)**.