2023

Summary of Benefits

Humana Premier Rx Plan (PDP) S5884-171

States of IA, MN, MT, ND, NE, SD, WY

Our service area includes the following state(s): Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming.

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Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-706-0872 (TTY: 711)**.

Understanding the Benefits

- [ ] The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **Humana.com/medicare** or call **1-800-706-0872 (TTY: 711)** to view a copy of the EOC.
- [ ] Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- [ ] Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- [ ] In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- [ ] Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.

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States of IA, MN, MT, ND, NE, SD, WY

Our service area includes the following state(s): Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming.

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Let's talk about Humana Premier Rx Plan (PDP)

Find out more about the Humana Premier Rx Plan (PDP) - including the drug services it covers - in this easy-to-use guide.

Humana Premier Rx Plan (PDP) is a stand-alone prescription drug 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".

To be eligible

To join Humana Premier Rx Plan (PDP), you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B and live in our service area.

Plan name:

Humana Premier Rx Plan (PDP)

How to reach us:

If you're a member of this plan, call toll-free: **1-800-281-6918 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-706-0872 (TTY: 711)**.

October 1 - March 31:
Call 7 days a week from 8 a.m. - 8 p.m.

April 1 - September 30:
Call Monday - Friday, 8 a.m. - 8 p.m.

Or visit our website:

Humana.com/medicare

More about Humana Premier Rx Plan (PDP)

Do you have Medicare and Medicaid? If you are a dual-eligible beneficiary enrolled in both Medicare and the state's program, your prescription drug costs may be lower.

If you have Medicaid, be sure to show your Medicaid ID card in addition to your Humana membership card to make your provider aware that you may have additional coverage. Your services are paid first by Humana and then by Medicaid.

Humana Premier Rx Plan (PDP) offers a pharmacy network with preferred cost sharing at select pharmacies. You may pay more at other pharmacies.

A healthy partnership

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

Monthly Premium, Deductible and Limits

Monthly Plan Premium	**$75.40** If you receive premium assistance, your plan premium may be reduced. If you have Part B, you must keep paying your Medicare Part B premium.
Pharmacy (Part D) deductible	No deductible for Tier 1 and Tier 2 **$300** for Tier 3, Tier 4, Tier 5

Prescription Drug Benefits

PRESCRIPTION DRUGS

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 **$300** deductible for Tier 3, Tier 4, Tier 5 drugs. You pay the full cost of these drugs until you reach **$300**. Then, you only pay your cost-share.

Initial coverage (after you pay your deductible)
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	**Standard** Walmart Mail, PillPack Other pharmacies are available in our network. To find 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	$5	$15	$1	$0
Tier 2: Generic	$10	$30	$4	$0
Tier 3: Preferred Brand	$47	$141	$45	$125
Tier 4: Non-Preferred Drug	50%	50%	49%	49%
Tier 5: Specialty Tier	28%	N/A	28%	N/A

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Retail Cost-Sharing				
Pharmacy options	**Standard** All other network retail pharmacies.		**Preferred** To find the preferred cost-share retail pharmacies near you, go to **Humana.com/pharmacyfinder**	
	30-day supply	**90-day supply***	**30-day supply**	**90-day supply***
Tier 1: Preferred Generic	$5	$15	$1	$3
Tier 2: Generic	$10	$30	$4	$12
Tier 3: Preferred Brand	$47	$141	$45	$135
Tier 4: Non-Preferred Drug	50%	50%	49%	49%
Tier 5: Specialty Tier	28%	N/A	28%	N/A

Your plan participates in the Insulin Savings Program. You will pay no more than $25 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. You are not eligible for this program if you receive "Extra Help".

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".

Your share of the cost for Select Insulins:

Mail Order Cost-Sharing for Select Insulins				
Pharmacy options	**Standard** Walmart Mail, PillPack Other pharmacies are available in our network. To find 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 3: Preferred Brand	**$25**	**$75**	**$20**	**$50**

Retail Cost-Sharing for Select Insulins				
Pharmacy options	**Standard** All other network retail pharmacies.		**Preferred** To find the preferred cost-share retail pharmacies near you, go to **Humana.com/pharmacyfinder**	
	30-day supply	**90-day supply***	**30-day supply**	**90-day supply***
Tier 3: Preferred Brand	**$25**	**$75**	**$20**	**$60**

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	**30-day supply**	**90-day supply***
brand drugs treated as generic), either:	**$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

ADDITIONAL DRUG COVERAGE	
Erectile dysfunction (ED) drugs	Covered at Tier 2 cost-share amount.

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 your prescription drug benefit, please call us or access your "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.

Coverage Gap

After you enter the coverage gap, you pay **25 percent** of the plan's cost for covered brand name drugs and **25 percent** of the plan's cost for covered generic drugs until your out-of-pocket costs total **$7,400** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, **you may pay even less** for the following:

Tier 1 (Preferred Generic) - All Drugs

Tier 2 (Generic) - All Drugs

Tier 3 (Preferred Brand) - Select Insulin Drugs

For more information on cost sharing in the coverage gap, please call us or access your Evidence of Coverage online.

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Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,400** you pay the greater of:

- **5%** of the cost, or
- **$4.15** copay for generic (including brand drugs treated as generic) and a **$10.35** copay for all other drugs

Find out **more**

You can see our plan's **pharmacy directory** at our website at **humana.com/finder/pharmacy/** 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 guide** at our website at **humana.com/medicaredruglist** or call us at the number listed at the beginning of this booklet and we will send you one.

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 Humana Prescription Drug Plan (PDP) pharmacy network includes limited lower-cost, preferred pharmacies in urban areas of CT, DE, IA, MA, ME, MN, MO, MS, ND, NJ, NY, PR, RI, SD; suburban areas of CT, MA, ME, MN, MT, ND, NH, NJ, NY, PA, PR, RI; and rural areas of IA, MN, MT, ND, NE, SD, VT, WY. There are an extremely limited number of preferred cost share pharmacies in urban areas in the following states: DE, ME, MN, MS, ND; suburban areas of: MT and ND; and rural areas of: ND. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call Customer Care at 1-800-281-6918 (TTY: 711) or consult the online pharmacy directory at **Humana.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, ethnicity, marital status, religion, or language. 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 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 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.

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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-320-1235 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-320-1235 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-320-1235 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다 . 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

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Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-320-1235 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-320-1235 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugues: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-320-1235 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康健康保険と薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-877-320-1235 (TTY: 711) にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

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