2020 **Health Plan Benefits** at a Glance

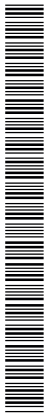
HumanaChoice® H5216-063 (PPO) Twin Cities

Plan Costs	With Medicare Only In - Network	With Medicare only Out-of-Network	With Medicare & State Cost-Share Protection
Monthly plan premium	$106		If you receive "Extra Help" from Medicare, depending on the level of "Extra Help" you received, the plan premium may be reduced
Annual out-of-pocket maximum	$3,000	$4,500 combined	$0
Doctor Office Visits			
Primary care provider (PCP)	$0 copay	20% of the cost	$0 copay
Specialist	$25 copay	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	$100 per admit	20% of the cost	$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	$10 copay	20% of the cost	$0 copay
Lab tests from outpatient hospital facility	$10 copay	20% of the cost	$0 copay
Outpatient Care			
Outpatient surgery at ambulatory surgical center	$50 copay	20% of the cost	$0 copay
Physical therapy at therapy facility	$40 copay	20% of the cost	$0 copay
X-rays at outpatient hospital facility	$85 copay	20% of the cost	$0 copay

Continued:

Outpatient Care (continued)			
Diagnostic testing at outpatient hospital facility	$85 copay	20% of the cost	$0 copay
Mental Health Services			
Inpatient psychiatric hospital	$100 per admit	20% of the cost	$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 $0 copay per day for days 150-190; 190 day lifetime limit in a psychiatric facility
Specialist's office	$40 copay	20% of the cost	$0 copay
Outpatient hospital	$85 copay	20% of the cost	$0 copay
Partial hospitalization	$55 copay	20% of the cost	$0 copay
Emergency Services			
Urgently needed services at an urgent care center	$25 copay	20% of the cost	$0 copay
Ground ambulance services	$265 per date of service	$265 per date of service	$0 copay
Emergency room	$120 copay	$120 copay	$0 copay
Additional Benefits & Programs			
Routine dental services DEN916	Included - cost share may apply. Please refer to the Summary of Benefits for additional details		
Routine vision services VIS751	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 $50 every 3 months		
SilverSneakers® fitness program	Included		

Additional Benefits & Programs (continued)	
Well Dine Meal Program	Included
Routine hearing services HER941	Included - cost share may apply. Please refer to the Summary of Benefits for additional details
Rewards and Incentives by Humana	Rewards for completing preventive health screenings/activities



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2020 **Prescription Drug Benefits** at a Glance

HumanaChoice® H5216-063 (PPO) Twin Cities

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

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 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	$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 **$4,020,** 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 **$89** depending on your level of Extra Help for Tier 4, Tier 5. If your deductible is **$89**, you pay the full cost of these drugs until you reach **$89**. Then, you only pay your cost-share.

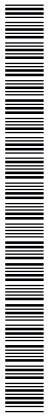
Pharmacy cost-sharing		
For generic drugs (including brand drugs treated as generic), either:	**30-day supply** $0 copay; or $1.30 copay; or $3.60 copay; or 15% of the cost	**90-day supply** $0 copay; or $1.30 copay; or $3.60 copay; or 15% of the cost
For all other drugs, either:	$0 copay; or $3.90 copay; or $8.95 copay; or 15% of the cost	$0 copay; or $3.90 copay; or $8.95 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, 2019 - Mar. 31, 2020 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.

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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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 identity, 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 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** .

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