2021

Summary of Benefits

Humana Premier Rx Plan (PDP) S5884-168

State of Texas

Our service area includes the following state(s): Texas.

Humana®

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

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. 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.

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, 2022.

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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	**$65.90** Depending on your level of Medicaid eligibility, your plan premium may be reduced. If you have Part B, you must keep paying your Medicare Part B premium.
Pharmacy (Part D) deductible	**$445** for Tier 3, Tier 4, Tier 5

Prescription Drug Benefits

PRESCRIPTION DRUGS

If you don't receive Extra Help for your drugs, you'll pay the following:
DeductibleThis plan has a **$445** deductible for Tier 3, Tier 4, Tier 5 drugs. You pay the full cost of these drugs until you reach $445. Then, you only pay your cost-share. There is no deductible for select insulins as part of the Insulin Savings Program. During this stage, you will pay no more than $35 for a one-month supply for select insulins. See the Additional Drug Coverage section of this document for additional details.

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach **$4,130**. 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. As part of the Insulin Savings Program, you will pay no more than $35 for a one-month supply for select insulins in the initial coverage stage. See the Additional Drug Coverage section of this document for specific details.

Preferred cost-sharing

Pharmacy options	**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	$1	$3	$1	$0
Tier 2: Generic	$4	$12	$4	$0
Tier 3: Preferred Brand	$45	$135	$45	$125
Tier 4: Non-Preferred Drug	49%	49%	49%	49%
Tier 5: Specialty Tier	25%	N/A	25%	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	$5	$15	$5	$15
Tier 2: Generic	$10	$30	$10	$30
Tier 3: Preferred Brand	$47	$141	$47	$141
Tier 4: Non-Preferred Drug	50%	50%	50%	50%
Tier 5: Specialty Tier	25%	N/A	25%	N/A

Generic drugs may be covered on tiers other than Tier 1 and Tier 2 so please check this plan's Humana Drug Guide to validate the specific tier on which your drugs are covered.

Specialty drugs are limited to a 30 day supply.

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

Deductible You may pay **$0** or **$92** depending on your level of Extra Help (for Tier 3, Tier 4, Tier 5). If your deductible is **$92**, you pay the full cost of these drugs until you reach **$92**. 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 **$1.30** copay; or **$3.70** copay ; or **15%** of the cost	**$0** copay; or **$1.30** copay; or **$3.70** copay ; or **15%** of the cost
For all other drugs, either:	**$0** copay; or **$4** copay; or **$9.20** copay ; or **15%** of the cost	**$0** copay; or **$4** copay; or **$9.20** copay ; or **15%** of the cost

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

This plan participates in the Insulin Savings Program which provides affordable, predictable copayments on select insulins through the first three drug payment stages (Deductible (if applicable), Initial Coverage and Coverage Gap) of the Part D benefit. The Insulin Savings Program does not apply to the Catastrophic Coverage stage. To find out which drugs are select insulins, please check this plan's Humana Drug Guide. You are not eligible for this program if you receive Extra Help.

Your share of the cost for select insulins through the Deductible Stage (if applicable), Initial Coverage Stage and Coverage Gap Stage as part of the Insulin Savings Program:

Preferred cost-sharing for select insulins				
Pharmacy options	**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 3: Preferred Brand	**$30**	**$90**	**$30**	**$80**
Standard cost-sharing for select insulins				
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 3: Preferred Brand	**$35**	**$105**	**$35**	**$105**

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 the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our "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.

Days' Supply Available

Unless otherwise specified, you can get your Part D drug in the following days' supply amounts:
- One month supply (up to 30 days)*
- Two month supply (31-60 days)
- Three month supply (61-90 days)

*Long term care pharmacy (one month supply = 31 days)

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 costs total **$6,550** — which is the end of the coverage gap. As part of the Insulin Savings Program, you will pay no more than $35 for a one-month supply for select insulins in the coverage gap. See the Additional Drug Coverage section of this document for specific details. Not everyone will enter the coverage gap.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,550**, you pay the greater of:
- **5%** of the cost, or
- **$3.70** copay for generic (including brand drugs treated as generic) and a **$9.20** copayment 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, MD, ME, MI, MN, MO, MS, MT, ND, NH, NJ, NY, PA, RI, SD, WY; suburban areas of CA, CT, DE, HI, IL, MA, MD, ME, MN, MT, ND, NH, NJ, NY, PA, PR, RI, VT, WV; and rural areas of AK, 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, MA, ME, MN, MS, ND, NY; 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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Humana.com

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 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.

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

Humana Premier Rx Plan (PDP)

S5884168000 ENG

State of Texas

Humana.com

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