For HENNEPIN, MN (55426)

Medicare Advantage Plan

Humana Honor PPO

PPO H5216-278-001

General Costs

Premiums & Deductibles	In-Network	Out-of-Network
Monthly premium	**$0.00** ?	
Part B premium reduction ?	**$55.00** rebate	
Medical deductible	**$0**	
This plan does not include prescription drug coverage.		
Your Annual Cost Estimates		
Annual plan premiums	**$0** ($0.00 premium x 12 months)	
Maximum Out-of-Pocket	In-Network	Out-of-Network
Maximum out-of-pocket responsibility	**$4,900**	**$10,000** combined in- and out-of-network
The out-of-pocket maximum is the maximum amount that you will be required to pay a year for deductibles, copayments, and coinsurance on covered services. It does not include the amount you pay for monthly premiums.		

Provider Costs & Coverage

Covered Doctor Copays	In-Network	Out-of-Network
Primary care copay	**$5** copay	**50%** of the cost
Specialist copay	**$45** copay	**50%** of the cost
Your Doctors & Coverage		
Provider network (estimated size) ?	**75,000** participating providers	

Hospital Costs

Hospital Costs

Hospital & Urgent Care	In-Network	Out-of-Network
Inpatient hospital care	**$295** copay per day for day 1 to 6 **$0** copay per day for day 7 to 90	**50%** of the cost
Outpatient surgery at hospital	**$250** copay	**50%** of the cost
Outpatient surgery at surgical center	**$200** copay	**50%** of the cost
Emergency room If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	**$90** copay	**$90** copay
Urgent care Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$25** copay	**50%** of the cost

Labs & X-Rays	In-Network	Out-of-Network
Cost share may vary depending on the service and where service is provided.		
Diagnostic procedures/tests	**$0-$50** copay	**50%** of the cost
Lab services	**$0-$40** copay	**50%** of the cost
Diagnostic radiological services	**$180-$250** copay	**50%** of the cost
X-ray services	**$5-$50** copay	**50%** of the cost

Other Benefits ?

Additional Benefits

Additional benefits may be available with a separate monthly premium. For more information see the **Summary of Benefits** PDF.

Routine vision coverage	**Routine dental coverage**	**Routine hearing coverage**	**Meal delivery service**

OTC drugs and supplies	**SilverSneakers® fitness program †**

Mental Health Services	In-Network	Out-of-Network
Inpatient care at a psychiatric facility Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	**$270** copay per day for day 1 to 6 **$0** copay per day for day 7 to 90	**50%** of the cost
Outpatient group and individual therapy visits Cost share may vary depending on where service is provided	**$40 - $55** copay	**50%** of the cost

Dental Benefits	In-Network	Out-of-Network
Additional dental benefits may be available with a separate monthly premium. For more information see the **Summary of Benefits**.		
Medicare-covered dental services	**$45** copay	**50%** of the cost
Routine Dental		
Bitewing x-rays up to 1 set(s) per year	**0%** of the cost	**0%** of the cost
Comprehensive oral evaluation or periodontal exam up to 1 every 3 years	**0%** of the cost	**0%** of the cost
Periodic oral exam up to 2 per year	**0%** of the cost	**0%** of the cost
Prophylaxis (cleaning) up to 2 per year	**0%** of the cost	**0%** of the cost
Amalgam and/or composite filling up to 2 per year	**$25** copay	**$25** copay

Necessary anesthesia with covered service up to unlimited per year	**0%** of the cost	**0%** of the cost
Maximum benefit	**$2,000** combined maximum benefit coverage amount per year	**$2,000** combined maximum benefit coverage amount per year Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Vision Benefits	In-Network	Out-of-Network
Additional vision benefits may be available with or without a separate monthly premium. For more information see the **Summary of Benefits**.		
Medicare-covered vision services	**$45** copay	**50%** of the cost
Diabetic eye exam	**$0** copay	**50%** of the cost
Glaucoma screening	**$0** copay	**50%** of the cost
Eyewear (post cataract surgery)	**$0** copay	**50%** of the cost
Routine Vision		
Routine exam up to 1 per year	**$0** copay	**$0** copay
Contact lenses or eyeglasses-lenses and frames up to 1 pair(s) per year	**$0** copay	**$0** copay
Fitting for eyeglasses-lenses and frames up to 1 per year	**$0** copay	**$0** copay
Max benefits: routine exam	**$75** combined maximum benefit coverage amount per year	**$75** combined maximum benefit coverage amount per year Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Max benefits: contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames	**$200** combined maximum benefit coverage amount per year	**$200** combined maximum benefit coverage amount per year Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Additional notes	Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage	Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage

	amount is limited to one time use per year.	amount is limited to one time use per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Hearing Benefits	In-Network	Out-of-Network
Additional hearing benefits may be available with a separate monthly premium. For more information see the **Summary of Benefits**.		
Medicare-covered hearing services	**$45** copay	**50%** of the cost
Routine Hearing		
Routine hearing exams up to 1 per year	**$0** copay	**$0** copay
Advanced level hearing aid up to 1 per ear per year	**$699** copay	**$699** copay
Premium level hearing aid up to 1 per ear per year	**$999** copay	**$999** copay

Preventive Benefits

In-network: $0 for the following preventive services when you see an in-network provider:

- Bone mass measurement
- Annual wellness visit
- Breast cancer screening (mammogram)
- Cardiovascular screenings
- Cervical and vaginal cancer screening
- Colorectal cancer screening
- Diabetes screening
- Immunizations
- Lung cancer screening
- Medicare diabetes prevention program (MDPP)
- Prostate cancer screening exam
- Routine physical exams

Out-of-network: $0 or 50% of the cost, depending on the service and where service is provided. For more details, see **Summary of Benefits**.

Plan Documents

Documents		
Summary of Benefits	View deductibles, copays and more.	**English** **Spanish**
Provider directory	Search the directory on Humana's	**List of providers**

	non-Medicare website.	
Pharmacy directory	Search the directory on Humana's non-Medicare website.	List of pharmacies
Printable prescription drug list	Visit Humana's non-Medicare website to see prescription drug tiers.	List of prescription drugs
Evidence of Coverage	See what's covered, and what you pay as a member of this plan.	English Spanish
CMS plan ratings	Check how Medicare rates this plan's quality and performance.	English Spanish