


Medicare Advantage Plan


Humana Gold Plus HMO

HMO POS H6622-073

General Costs

Premiums & Deductibles	In-Network	Out-of-Network
Monthly premium	\$0.00 	
Medical deductible	\$0	
Prescription drug deductibles	\$350 for Tier 3, Tier 4, Tier 5	
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	\$5,100	\$8,000 combined in- and out-of-network
<p>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.</p>		

Provider Costs & Coverage

Covered Doctor Copays	In-Network	Out-of-Network
Primary care copay	\$0 copay	30% of the cost
Specialist copay	\$45 copay	30% of the cost
Your Doctors & Coverage		
Provider network (estimated size) 	22,000 participating providers	

Prescription Drug Costs & Coverage

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Your Pharmacies & Prescription Drugs

Your Prescription Drugs

 [Add your Rx drugs](#) to see if they are covered on this plan and review cost estimates.

Preferred Retail Pharmacy Costs - 30 Day Supply

To find the preferred cost-share retail pharmacies near you, go to [Humana Pharmacy Finder](#) 

Deductible Stage

This plan has a \$350 deductible for preferred and non-preferred brand drugs and specialty drugs (Tiers 3, 4, 5). You pay the full cost of these drugs until you reach \$350. Then, you will only pay the initial coverage costs (Initial Coverage Stage). There is a \$0 deductible for preferred and non-preferred generic drugs (Tiers 1, 2).

Preferred generic drugs (Tier 1)	\$5 copay
Non-preferred generic drugs (Tier 2)	\$10 copay
Preferred brand-name drugs (Tier 3)	Member pays 100% until the deductible is met
Non-preferred brand-name drugs (Tier 4)	Member pays 100% until the deductible is met
Specialty drugs (Tier 5)	Member pays 100% until the deductible is met

Initial Coverage Stage

You pay the initial coverage costs below until your total yearly drug costs reach \$4,430. Total yearly drug costs are the total drug costs paid by both you and Humana. Once you reach \$4,430, you will enter the coverage gap (Coverage in the Gap Stage).

Preferred generic drugs (Tier 1)	\$5 copay
Non-preferred generic drugs (Tier 2)	\$10 copay
Preferred brand-name drugs (Tier 3)	\$47 copay
Non-preferred brand-name drugs (Tier 4)	\$100 copay
Specialty drugs (Tier 5)	27% coinsurance

Coverage in the Gap Stage

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 \$7,050 — which is the end of the coverage gap. Not everyone will enter the coverage gap. See Evidence of Coverage for complete details.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$7,050, you pay the greater of:

- 5% of the cost, or
- \$3.95 copay for generic (including brand drugs treated as generic) and a \$9.85 copayment for all other drugs

Hospital Costs

Hospital & Urgent Care	In-Network	Out-of-Network
Inpatient hospital care	\$350 copay per day for day 1 to 5 \$0 copay per day for day 6 to 90	30% of the cost
Outpatient surgery at hospital	\$350 copay	30% of the cost
Outpatient surgery at surgical center	\$300 copay	30% 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.	\$30 copay	30% 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-\$95 copay	30% of the cost
Lab services	\$0-\$45 copay	30% of the cost
Diagnostic radiological services	\$180-\$350 copay	30% of the cost
X-ray services	\$0-\$95 copay	30% 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 †



Insulin Savings Program

Mental Health Services

In-Network

Out-of-Network

Inpatient care at a psychiatric facility

\$350 copay per day for day 1 to 5
\$0 copay per day for day 6 to 90

30% of the cost

Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.

Outpatient group and individual therapy visits

\$40 - \$95 copay

30% of the cost

Cost share may vary depending on where service is provided

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 PDF](#).

Medicare-covered dental services

\$45 copay

30% 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
Necessary anesthesia with covered service up to unlimited per year	0% of the cost	0% of the cost
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 PDF.		
Medicare-covered vision services	\$45 copay	30% of the cost
Diabetic eye exam	\$0 copay	30% of the cost
Glaucoma screening	\$0 copay	30% of the cost
Eyewear (post cataract surgery)	\$0 copay	30% 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	\$100 combined maximum benefit coverage amount per year	\$100 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 amount is limited to one time use	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.

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

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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 PDF](#).

Medicare-covered hearing services

\$45 copay

30% 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

Optional Coverage Upgrades

This plan offers optional coverage upgrades which can be added to your plan for an additional cost. These upgrades are designed to help you manage costs for more serious procedures or non-routine care. The following upgrades are available for an additional monthly premium.

MyOption DEN205

+ **\$110.20** Monthly premium

[View details PDF](#)

MyOption DEN204

+ **\$79.00** Monthly premium









[View details PDF](#)

Preventive Benefits

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

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| <ul style="list-style-type: none">• Bone mass measurement• Cardiovascular screenings• Diabetes screening• Medicare diabetes prevention program (MDPP) | <ul style="list-style-type: none">• Annual wellness visit• Cervical and vaginal cancer screening• Immunizations• Prostate cancer screening exam | <ul style="list-style-type: none">• Breast cancer screening (mammogram)• Colorectal cancer screening• Lung cancer screening• Routine physical exams |
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Plan Documents

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