

Medicare Advantage Plan


**Humana Gold Plus HMO**

HMO POS H6622-062

## General Costs

Premiums & Deductibles	In-Network	Out-of-Network
Monthly premium	<b>\$128.00</b> Receive help paying for prescription drug costs? <a href="#">See adjusted premium</a>	
Medical deductible	<b>\$0</b>	
Prescription drug deductibles	<b>\$100</b> for Tier 4, Tier 5	
<b>Your Annual Cost Estimates</b>		
<b>Annual plan premiums</b>	<b>\$1,536</b> (\$128.00 premium x 12 months)	
<b>Maximum Out-of-Pocket</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Maximum out-of-pocket responsibility	<b>\$3,000</b>	<b>\$5,000</b> 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 &amp; Coverage

Covered Doctor Copays	In-Network	Out-of-Network
Primary care copay	<b>\$0</b> copay	<b>\$0</b> copay
Specialist copay	<b>\$20</b> copay	<b>\$20</b> copay
<b>Your Doctors &amp; Coverage</b>		
Provider network (estimated size) 	<b>22,000</b> participating providers	

## Prescription Drug Costs &amp; Coverage

Prescription Drug Costs & Coverage

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 \$100 deductible for preferred and non-preferred brand drugs and specialty drugs (Tiers 4, 5). You pay the full cost of these drugs until you reach \$100. 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, 3).

Preferred generic drugs (Tier 1)      **\$0** copay

Non-preferred generic drugs (Tier 2)      **\$6** copay

Preferred brand-name drugs (Tier 3)      **\$47** copay

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)      **\$0** copay

Non-preferred generic drugs (Tier 2)      **\$6** copay

Preferred brand-name drugs (Tier 3)      **\$47** copay

Non-preferred brand-name drugs (Tier 4)      **\$100** copay

Specialty drugs (Tier 5)      **31%** 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	<b>\$100</b> copay per admission	<b>\$200</b> copay per admission
Outpatient surgery at hospital	<b>\$100</b> copay	<b>20%</b> of the cost
Outpatient surgery at surgical center	<b>\$50</b> copay	<b>20%</b> 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.	<b>\$120</b> copay	<b>\$120</b> copay
Urgent care Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	<b>\$20</b> copay	<b>\$20</b> copay
<b>Labs &amp; X-Rays</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Cost share may vary depending on the service and where service is provided.		
Diagnostic procedures/tests	<b>\$0-\$80</b> copay	<b>\$0-\$80</b> copay
Lab services	<b>\$0-\$20</b> copay	<b>\$0-\$20</b> copay
Diagnostic radiological services	<b>\$50-\$100</b> copay	<b>\$50-\$200</b> copay
X-ray services	<b>\$0-\$80</b> copay	<b>\$0-\$80</b> copay

**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 †**



**Transportation**



**Insulin Savings 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.

**\$100** copay per admission

**\$200** copay per admission

Outpatient group and individual therapy visits

Cost share may vary depending on where service is provided

**\$20 - \$70** copay

**\$20 - \$70** copay

**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

**\$20** copay

**\$20** copay

**Routine Dental**

Bitewing x-rays up to 1 set(s) per year

**0%** of the cost









**50%** of the cost

Comprehensive oral evaluation or periodontal exam up to 1 every 3 years	0% of the cost	50% of the cost
Periodic oral exam and/or emergency diagnostic exam up to 2 per year	0% of the cost	50% of the cost
Prophylaxis (cleaning) up to 2 per year	0% of the cost	50% of the cost
Amalgam and/or composite filling up to 2 per year	50% of the cost	55% of the cost
Simple or surgical extraction up to unlimited per year	50% of the cost	55% of the cost
Necessary anesthesia with covered service up to unlimited per year	0% of the cost	50% of the cost
Maximum benefit	<b>\$2,000</b> combined maximum benefit coverage amount per year	<b>\$2,000</b> combined maximum benefit coverage amount per year Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
<b>Vision Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Additional vision benefits may be available with or without a separate monthly premium. For more information see the <a href="#">Summary of Benefits</a> PDF.		
Medicare-covered vision services	<b>\$20</b> copay	<b>\$20</b> copay
Diabetic eye exam	<b>\$0</b> copay	<b>\$0</b> copay
Glaucoma screening	<b>\$0</b> copay	<b>\$0</b> copay
Eyewear (post cataract surgery)	<b>\$0</b> copay	<b>\$0</b> copay
<b>Routine Vision</b>		

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 amount is limited to one time use per year.	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. 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.		
<b>Hearing Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Additional hearing benefits may be available with a separate monthly premium. For more information see the <a href="#">Summary of Benefits PDF</a> .		
Medicare-covered hearing services	\$20 copay	\$20 copay
<b>Routine Hearing</b>		
Routine hearing exams up to 1 per year	\$0 copay	\$0 copay

Advanced level hearing aid up to 1 per ear per year	\$399 copay	\$399 copay
Premium level hearing aid up to 1 per ear per year	\$699 copay	\$699 copay
<b>Preventive Benefits</b>		
In-network: \$0 for the following preventive services when you see an in-network provider:		
<ul style="list-style-type: none"> <li>Bone mass measurement</li> <li>Cardiovascular screenings</li> <li>Diabetes screening</li> <li>Medicare diabetes prevention program (MDPP)</li> </ul>	<ul style="list-style-type: none"> <li>Annual wellness visit</li> <li>Cervical and vaginal cancer screening</li> <li>Immunizations</li> <li>Prostate cancer screening exam</li> </ul>	<ul style="list-style-type: none"> <li>Breast cancer screening (mammogram)</li> <li>Colorectal cancer screening</li> <li>Lung cancer screening</li> <li>Routine physical exams</li> </ul>

## Plan Documents

<b>Documents</b>		
Summary of Benefits	View deductibles, copays and more.	<a href="#">English</a>  <a href="#">Spanish</a> 
Provider directory	Search the directory on Humana's non-Medicare website.	<a href="#">List of providers</a> 
Pharmacy directory	Search the directory on Humana's non-Medicare website.	<a href="#">List of pharmacies</a> 
Printable prescription drug list	Visit Humana's non-Medicare website to see prescription drug tiers.	<a href="#">List of prescription drugs</a> 
Evidence of Coverage	See what's covered, and what you pay as a member of this plan.	<a href="#">English</a>  <a href="#">Spanish</a> 
CMS plan ratings	Check how Medicare rates this plan's quality and performance.	<a href="#">English</a>  <a href="#">Spanish</a> 