Medicare Advantage Plan

HumanaChoice PPO

PPO H5216-167

General Costs

Premiums & Deductibles	In-Network	Out-of-Network
Monthly premium	**$78.00** Receive help paying for prescription drug costs? See adjusted premium	
Medical deductible	**$0**	
Prescription drug deductibles	**$350** for Tier 4, Tier 5	
Your Annual Cost Estimates		
Annual plan premiums	**$936** ($78.00 premium x 12 months)	
Maximum Out-of-Pocket	**In-Network**	**Out-of-Network**
Maximum out-of-pocket responsibility	**$4,000**	**$6,000** 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	**$0** copay	**20%** of the cost
Specialist copay	**$35** copay	**20%** of the cost
Your Doctors & Coverage		
Provider network (estimated size) ?	**46,000** participating providers	

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 $350 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 $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, 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)	**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	**$100** copay per day for day 1 to 7 **$0** copay per day for day 8 to 90	**20%** of the cost
Outpatient surgery at hospital	**$100** copay	**20%** of the cost
Outpatient surgery at surgical center	**$75** copay	**20%** 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	**20%** 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**-**$85** copay	**20%** of the cost
Lab services	**$0**-**$25** copay	**20%** of the cost
Diagnostic radiological services	**$50**-**$100** copay	**20%** of the cost
X-ray services	**$0**-**$85** copay	**20%** 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.

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 Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	**$100** copay per day for day 1 to 7 **$0** copay per day for day 8 to 90	**20%** of the cost
Outpatient group and individual therapy visits Cost share may vary depending on where service is provided	**$35 - $85** copay	**20%** 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	**$35** copay	**20%** of the cost
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 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 2 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	**$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** PDF.		
Medicare-covered vision services	**$35** copay	**20%** of the cost
Diabetic eye exam	**$0** copay	**20%** of the cost
Glaucoma screening	**$0** copay	**20%** of the cost
Eyewear (post cataract surgery)	**$0** copay	**20%** 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	**$100** combined maximum benefit	**$100** combined maximum benefit

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 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.

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	**$35** copay	**20%** 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
- Cardiovascular screenings
- Diabetes screening
- Medicare diabetes prevention program (MDPP)
- Annual wellness visit
- Cervical and vaginal cancer screening
- Immunizations
- Prostate cancer screening exam
- Breast cancer screening (mammogram)
- Colorectal cancer screening
- Lung cancer screening
- Routine physical exams

Out-of-network: $0 or 20% of the cost, depending on the service and where service is provided. For more details, see **Summary of Benefits** PDF.

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