

Summary of Benefits

Humana Gold Plus H1468-013 (HMO)

Chicago (Cook, DuPage, Lake, Will)

Cook, DuPage, Kankakee, Lake, and Will counties

Our service area includes the following county/counties in Illinois: Cook, DuPage, Kankakee, Lake, Will.

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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 **1-800-833-2364 (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 **1-800-833-2364 (TTY: 711)** to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- 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

- You do not pay a separate monthly plan premium for this Humana plan but, 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, 2023.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

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Let's talk about Humana Gold Plus H1468-013 (HMO)

Find out more about the Humana Gold Plus H1468-013 (HMO) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus H1468-013 (HMO) is a Medicare Advantage HMO 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 Gold Plus H1468-013 (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

Humana Gold Plus H1468-013 (HMO)

How to reach us:

If you're a member of this plan, call toll-free: **1-800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-833-2364 (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 Gold Plus H1468-013 (HMO)

Do you have Medicare and Medicaid? If you are a dual-eligible beneficiary enrolled in both Medicare and the state's program, you may not have to pay the medical costs displayed in this booklet and your prescription drug costs will be lower, too.

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.

As a member you must select an in-network doctor to act as your Primary Care Provider (PCP). Humana Gold Plus H1468-013 (HMO) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services.



A healthy partnership

Get more from your plan — with extra services and resources provided by Humana!



Monthly Premium, Deductible and Limits

Monthly Plan Premium	\$0 You must keep paying your Medicare Part B premium.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	This plan does not have a deductible.
Maximum out-of-pocket responsibility	\$2,600 in-network The most you pay for copays, coinsurance and other costs for medical services for the year.



Covered Medical and Hospital Benefits

Acute inpatient hospital care	\$150 copay per day for days 1-7 \$0 copay per day for days 8-90 Your plan covers an unlimited number of days for an inpatient stay.
Outpatient hospital coverage	<ul style="list-style-type: none"> • Outpatient surgery at Outpatient Hospital: \$150 copay • Outpatient surgery at Ambulatory Surgical Center: \$100 copay
Doctor visits	<ul style="list-style-type: none"> • Primary care provider: \$0 copay • Specialist: \$20 copay

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a referral and/or prior authorization from the plan.



Covered Medical and Hospital Benefits (cont.)

Preventive care

Our plan covers many preventive services at no cost when you see an in-network provider including:

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screenings
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screening
- Diabetes screenings
- HIV screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screening and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, including flu shots, hepatitis B shots, pneumococcal shots
- "Welcome to Medicare" preventive visit (one-time)
- Annual Wellness Visit
- Lung cancer screening
- Routine physical exam
- Medicare diabetes prevention program

Any additional preventive services approved by Medicare during the contract year will be covered.

EMERGENCY CARE

Emergency room

\$120 copay

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.

Urgently needed services

\$20 copay at an urgent care center

Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.

OUTPATIENT CARE AND SERVICES

Diagnostic services, labs and imaging

Cost share may vary depending on the service and where service is provided

- Diagnostic mammography: **\$20** copay
- Diagnostic radiology: **\$0** to **\$150** copay
- Lab services: **\$0** to **\$20** copay
- Diagnostic tests and procedures: **\$0** to **\$20** copay
- Outpatient X-rays: **\$0** to **\$25** copay
- Radiation therapy: **20%** of the cost

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Covered Medical and Hospital Benefits (cont.)

Hearing

Medicare-covered hearing exam: **\$20** copay

Routine hearing:

In-Network:

HER946

- **\$0** copayment for routine hearing exams up to 1 per year.
- **\$199** copayment for each Advanced level hearing aid up to 1 per ear per year.
- **\$499** copayment for each Premium level hearing aid up to 1 per ear per year.

Hearing aid purchase includes:

- Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase
- 60-day trial period
- 3-year extended warranty
- 80 batteries per aid for non-rechargeable models

You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (for TTY, dial 711).

Dental

Medicare-covered dental services: **\$20** copay

Routine dental:

The cost-share indicated below is what you pay for the covered service.

In-Network:

DEN770

- **0%** coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.
- **0%** coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years.
- **0%** coinsurance for bitewing x-rays up to 1 set(s) per year.
- **0%** coinsurance for intraoral x-rays up to 1 per year.
- **0%** coinsurance for periodic oral exam, prophylaxis (cleaning) up to 2 per year.
- **0%** coinsurance for necessary anesthesia with covered service up to unlimited per year.
- **50%** coinsurance for amalgam and/or composite filling, simple or surgical extraction up to 2 per year.
- **70%** coinsurance for complete dentures, partial dentures up to 1 set(s) every 5 years.
- **70%** coinsurance for adjustments to dentures, crown, denture relines up to 1 per year.
- **\$2000** maximum benefit coverage amount per year for preventive and comprehensive benefits.

Dental benefits may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**.

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a referral and/or prior authorization from the plan.



Covered Medical and Hospital Benefits (cont.)

H1468013000

Use the HumanaDental Medicare network for the Mandatory Supplemental Dental. The provider locator can be found at **Humana.com** > Find a Doctor > from the Search Type drop down select Dental > under Coverage Type select All Dental Networks > enter zip code > from the network drop down select HumanaDental Medicare.

Vision

- Medicare-covered vision services: **\$20** copay
- Medicare-covered diabetic eye exam: **\$0** copay
- Medicare-covered glaucoma screening: **\$0** copay
- Medicare-covered eyewear (post-cataract): **\$0** copay

Routine vision:

In-Network:

VIS733

- **\$0** copayment for routine exam up to 1 per year.
- **\$300** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.
- 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.

Refraction is only covered when billed as part of the routine vision exam.

The provider locator for routine vision can be found at **Humana.com** > Find a Doctor > select Vision care icon > Vision coverage through Medicare Advantage plans.

Mental health services

Inpatient:

- **\$150** copay per day for days 1-7
- **\$0** copay per day for days 8-90
- 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): **\$20** to **\$100** copay
Cost share may vary depending on where service is provided.

Skilled nursing facility (SNF)

- **\$20** copay per day for days 1-20
- **\$188** copay per day for days 21-100
- Your plan covers up to 100 days in a SNF

Physical Therapy

- **\$20** copay

ADDITIONAL BENEFITS

Ambulance (ground)

\$220 copay per date of service

Ambulance (air)

20% of the cost

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a referral and/or prior authorization from the plan.



Covered Medical and Hospital Benefits (cont.)

Transportation

\$0 copay for plan approved location up to 24 one-way trip(s) per year. This benefit is not to exceed 25 miles per trip.

The member *must* contact transportation vendor to arrange transportation.



Prescription Drug Benefits

Medicare Part B drugs

- Chemotherapy drugs: **20%** of the cost
- Other Part B drugs: **20%** of the cost

PRESCRIPTION DRUGS

If you don't receive Extra Help for your drugs, you'll pay the following:

Deductible This plan does not have a deductible.

Initial coverage

You pay the following until your total yearly drug costs reach **\$4,430**. 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 (up to a 30-day) 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		Mail order	
	30-day supply	90-day supply	30-day supply	90-day supply
Tier 1: Preferred Generic	\$0	\$0	\$0	\$0
Tier 2: Generic	\$5	\$15	\$5	\$0
Tier 3: Preferred Brand	\$47	\$141	\$47	\$131
Tier 4: Non-Preferred Drug	\$100	\$300	\$100	\$290
Tier 5: Specialty Tier	33%	N/A	33%	N/A

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a referral and/or prior authorization from the plan.

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	\$10	\$30	\$10	\$30
Tier 2: Generic	\$20	\$60	\$20	\$60
Tier 3: Preferred Brand	\$47	\$141	\$47	\$141
Tier 4: Non-Preferred Drug	\$100	\$300	\$100	\$300
Tier 5: Specialty Tier	33%	N/A	33%	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.

Other pharmacies are available in our network.

Specialty drugs are limited to a 30-day supply.

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

Deductible This plan does not have a deductible.

Pharmacy cost-sharing

	30-day supply	90-day supply
For generic drugs (including brand drugs treated as generic), either:	\$0 copay; or \$1.35 copay; or \$3.95 copay ; or 15% of the cost	\$0 copay; or \$1.35 copay; or \$3.95 copay ; or 15% of the cost
For all other drugs , either:	\$0 copay; or \$4 copay; or \$9.85 copay ; or 15% of the cost	\$0 copay; or \$4 copay; or \$9.85 copay ; or 15% of the cost

ADDITIONAL DRUG COVERAGE

Erectile dysfunction (ED) drugs Covered at Tier 1 cost-share amount.

Anti-Obesity 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 can identify Select Insulins by the "ISP" indicator in the 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	\$35	\$105	\$35	\$95

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 your "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 **\$7,050** — 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 (up to a 30-day) 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.

Under this plan, you may pay even less for the following:

Tier 3 (Preferred Brand) - Select Insulin Drugs

For more information on cost sharing in the coverage gap, please call us or access your Evidence of Coverage online.

Catastrophic Coverage

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



Additional Benefits

Medicare-covered foot care (podiatry) **\$20** copay

Medicare-covered chiropractic services **\$0** copay

Medical equipment/ supplies

Cost share may vary depending on the service and where service is provided

- Durable medical equipment (like wheelchairs or oxygen): **20%** of the cost
- Medical supplies: **20%** of the cost
- Prosthetics (artificial limbs or braces): **20%** of the cost
- Diabetic monitoring supplies: **\$0** copay or **10%** to **20%** of the cost

Rehabilitation services

- Occupational and speech therapy: **\$20** copay
- Cardiac rehabilitation: **\$0** copay
- Pulmonary rehabilitation: **\$0** copay

Telehealth services (in addition to Original Medicare)

- Primary care provider (PCP): **\$0** copay
- Specialist: **\$20** copay
- Urgent care services: **\$0** copay
- Substance abuse and behavioral health services: **\$0** copay



More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

COVID-19 Testing and Treatment

\$0 copay for testing and treatment services for COVID-19.

Chiropractic services

Routine chiropractic:

\$0 copay per visit for up to 12 visits.

Routine foot care

\$20 copay per visit for up to 2 visits.

Humana Well Dine® Meal Program

Humana's meal program for members following an inpatient stay in the hospital or nursing facility.

Over-the-Counter (OTC) mail order

\$125 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products.

Personal Home Care

\$0 copay for a minimum of 3 hours per day, up to a maximum of 42 hours per year for certain in-home services to assist individuals with disabilities and/or medical conditions in performing activities of daily living (ADLs) within the home by a qualified aide (e.g., assistance with bathing, dressing, toileting, walking, eating, and preparing meals).

Authorization may be required. Contact the plan for details.

Rewards and Incentives

Go365 by Humana® a Rewards and Incentive program for completing certain preventive health screenings and health and wellness activities.

SilverSneakers® fitness program

Basic fitness center membership including fitness classes.



Find out **more**



You can see our plan's **provider and pharmacy directory** at our website at **humana.com/finder/search** 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.

Medicare-covered eye refractions during a specialist medical visit are not covered.

Telehealth services shown are in addition to the Original Medicare covered telehealth. Your cost may be different for Original Medicare telehealth.

Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services are for informational purposes only and should not be construed as medical advice. Please refer to your evidence of coverage for additional details on what your plan may cover or other rules that may apply.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

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): Wóda hí béésh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá jii'eh saad bee áká'ánída'áwo'déé nika'adoowoł.

العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

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H1468013000 ENG
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