# 2023 **Health Plan Benefits** at a Glance

Humana Gold Choice H8145-120 (PFFS) Select Counties in AR, KS, MO and OK

| Plan Costs | With Medicare Only |
|---|---|
| Monthly plan premium | $31 |
| Medical deductible | $150 combined<br><br>Services not covered by Original Medicare, Primary Care Physician's Office, Ambulance services, Emergency Room services, Urgently Needed Services at Urgent Care Centers, Immunizations (Flu & Pneumonia), Medicare Covered Preventive services, Diabetic Monitoring Supplies, Chemotherapy Drugs and Administration, and Medicare Part B Covered Drugs do not apply to the combined in-network and out-of-network deductible. |
| Annual out-of-pocket maximum | $6,700 combined in-network<br>$6,700 combined out-of-network |

| | With Medicare only In-Network | With Medicare only Out-of-Network |
|---|---|---|
| **Doctor Office Visits** | | |
| Primary care provider (PCP) | $10 copay | 40% of the cost |
| Specialist | $40 copay | 40% of the cost |
| **Preventive Care** | | |
| Including: Medicare covered screenings | Covered at no cost when you see an in-network provider | Many preventive screenings covered at no cost when you see an in-network provider. |
| **Telehealth Services (in addition to Original Medicare)** | | |
| Primary care provider (PCP) | $0 copay | Not covered |
| Specialist | $40 copay | Not covered |
| Urgent care services | $0 copay | Not covered |
| Substance abuse or behavioral health services | $0 copay | Not covered |
| **Inpatient Care** | | |
| Acute inpatient hospital care | $360 copay per day for days 1-5<br>$0 copay per day for days 6-90 | 40% of the cost |

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| | | |
|---|---|---|
| **Lab Services** | | |
| Lab tests from lab facility | $0 copay | 40% of the cost |
| Lab tests from outpatient hospital facility | 25% of the cost | 40% of the cost |
| **Outpatient Care** | | |
| Outpatient surgery at ambulatory surgical center | 20% of the cost | 40% of the cost |
| Physical therapy at therapy facility | $35 copay | 40% of the cost |
| X-rays at outpatient hospital facility | 20% of the cost | 40% of the cost |
| Diagnostic testing at outpatient hospital facility | 20% of the cost | 40% of the cost |
| **Mental Health Services** | | |
| Inpatient psychiatric hospital<br><br>Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. | $318 copay per day for days 1-5<br>$0 copay per day for days 6-90 | 40% of the cost |
| Specialist's office | $40 copay | 40% of the cost |
| Outpatient hospital | 20% of the cost | 40% of the cost |
| Partial hospitalization | $40 copay | 40% of the cost |
| **Emergency Services** | | |
| Urgently needed services at an urgent care center | $30 copay | $30 copay |
| Ground ambulance services | $265 copay per date of service | $265 copay per date of service |
| Emergency room | $95 copay | $95 copay |
| **Additional Benefits & Programs** | | |
| Routine dental services DEN356 | Included - cost share may apply. Please refer to the Summary of Benefits for additional details. | |
| Routine vision services VIS752 | Included - cost share may apply. Please refer to the Summary of Benefits for additional details. | |
| Routine hearing services HER944 | Included - cost share may apply. Please refer to the Summary of Benefits for additional details. | |
| Humana Well Dine® Meal Program | Included | |

If you have questions and are a Humana member, please contact Customer Care at 1-800-457-4708 (TTY: 711). If you are not currently a Humana member, please contact a licensed Humana sales agent at 1-844-775-9622 (TTY: 711), 8 a.m. - 8 p.m. seven days a week from Oct. 1, 2022 - Mar. 31, 2023 and Monday through Friday the rest of the year.

Humana is a Medicare Advantage PFFS plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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.

Out-of-network/non-contracted providers are under no obligation to treat Humana members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Get all your health plan details at
**Humana.com/Benefits**

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# Important

## At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities.

- The following department has been designated to handle inquiries regarding Humana's non-discrimination policies: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235** (**TTY: 711)**.

## Auxiliary aids and services, free of charge, are available to you. 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.

## This information is available for free in other languages. Please call our customer service number at 877-320-1235 (TTY: 711). Hours of operation: 8 a.m. – 8 p.m. Eastern time.

**Español (Spanish):** Llame al número indicado para recibir servicios gratuitos de asistencia lingüística. **877-320-1235 (TTY: 711)**. Horas de operación: 8 a.m. a 8 p.m. hora del este.

**繁體中文 (Chinese):** 本資訊也有其他語言版本可供免費索取。請致電客戶服務部：**877-320-1235（聽障專線：711）**。辦公時間：東部時間上午 8 時至晚上 8 時。

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