

# 2020 Health Plan Benefits at a Glance

Humana Gold Plus<sup>®</sup> H6622-001 (HMO) Green Bay

<b>Plan Costs</b>	<b>With Medicare Only In - Network</b>	<b>With Medicare &amp; State Cost-Share Protection</b>
Monthly plan premium	\$0	\$0
Annual out-of-pocket maximum	\$5,000	\$0
<b>Doctor Office Visits</b>		
Primary care provider (PCP)	\$0 copay	\$0 copay
Specialist	\$50 copay	\$0 copay
<b>Preventive Care</b>		
Including: Medicare covered screenings	Covered at no cost when you see an in-network provider	\$0 copay
<b>Inpatient Care</b>		
Acute inpatient hospital care	\$325 copay per day for days 1-5 \$0 copay per day for days 6-90	\$0 deductible \$0 copay per day for days 1-60 \$0 copay per day for days 61-90 \$0 copay per day for days 91-150
<b>Lab Services</b>		
Lab tests from lab facility	\$0 copay	\$0 copay
Lab tests from outpatient hospital facility	\$40 copay	\$0 copay
<b>Outpatient Care</b>		
Outpatient surgery at ambulatory surgical center	\$200 copay	\$0 copay
Physical therapy at therapy facility	\$40 copay	\$0 copay
X-rays at outpatient hospital facility	\$100 copay	\$0 copay
Diagnostic testing at outpatient hospital facility	\$95 copay	\$0 copay
<b>Mental Health Services</b>		
Inpatient psychiatric hospital	\$325 copay per day for days 1-5 \$0 copay per day for days 6-90	\$0 deductible \$0 copay per day for days 1-60 \$0 copay per day for days 61-90 \$0 copay per day for days 91-150 \$0 copay per day for days 150-190; 190 day lifetime limit in a psychiatric facility
Specialist's office	\$40 copay	\$0 copay
Outpatient hospital	\$100 copay	\$0 copay
Partial hospitalization	\$55 copay	\$0 copay

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## Emergency Services

Urgently needed services at an urgent care center	\$25 copay	\$0 copay
Ground ambulance services	\$265 per date of service	\$0 copay
Emergency room	\$90 copay	\$0 copay

## Additional Benefits & Programs

Routine dental services DEN120	Included - cost share may apply. Please refer to the Summary of Benefits for additional details	
Routine vision services VIS736	Included - cost share may apply. Please refer to the Summary of Benefits for additional details	
Over-the-Counter (OTC) mail order	\$0 copay; up to \$50 every 3 months	
SilverSneakers® fitness program	Included	
Well Dine Meal Program	Included	
Routine hearing services HER814	Included - cost share may apply. Please refer to the Summary of Benefits for additional details	
Rewards and Incentives by Humana	Rewards for completing preventive health screenings/activities	



# 2020 Prescription Drug Benefits at a Glance

Humana Gold Plus<sup>®</sup> H6622-001 (HMO) Green Bay

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

**Deductible** This plan has a **\$295** deductible for Tier 4, Tier 5 drugs. You pay the full cost of these drugs until you reach \$295. Then, you only pay your cost-share.

**Initial Coverage** In this stage, you may pay a cost-share that is either a **copay** — a set dollar amount — or **coinsurance** — a set percentage amount you pay each time you fill your drug.

### Preferred cost-sharing

Pharmacy options <b>Get more value with cost-share options in bold</b>	Retail To find the preferred cost-share retail pharmacies near you, go to <a href="http://Humana.com/pharmacyfinder">Humana.com/pharmacyfinder</a>		Mail Order Humana Pharmacy <sup>®</sup>	
	30-day supply	90-day supply*	30-day supply	90-day supply*
<b>Tier 1:</b> Preferred Generic	\$6	\$18	\$6	<b>\$0</b>
<b>Tier 2:</b> Generic	\$15	\$45	\$15	<b>\$0</b>
<b>Tier 3:</b> Preferred Brand	\$47	\$141	\$47	<b>\$131</b>
<b>Tier 4:</b> Non-Preferred Drug	\$100	\$300	\$100	<b>\$290</b>
<b>Tier 5:</b> Specialty Tier	27%	N/A	27%	N/A

### Standard cost-sharing

Pharmacy options	Retail All other network retail pharmacies.		Mail Order Walmart Mail	
	30-day supply	90-day supply*	30-day supply	90-day supply*
<b>Tier 1:</b> Preferred Generic	\$10	\$30	\$10	\$30
<b>Tier 2:</b> Generic	\$20	\$60	\$20	\$60
<b>Tier 3:</b> Preferred Brand	\$47	\$141	\$47	\$141
<b>Tier 4:</b> Non-Preferred Drug	\$100	\$300	\$100	\$300
<b>Tier 5:</b> Specialty Tier	27%	N/A	27%	N/A

Once your total yearly drug cost—what is paid both by you and our plan—reach **\$4,020**, the costs of your drugs may go up. Please refer to the Summary of Benefits for more information.

You can get more out of your plan by doing the following:

- **Stay in-network.** You'll pay less for your drugs at in-network pharmacies.
- **Use preferred cost-sharing pharmacies.** They offer a lower cost-share than standard cost-sharing pharmacies for most drugs (your cost-share for specialty drugs is the same at any in-network pharmacy).
- **Get a 90-day supply of many of the drugs you take all of the time.** You'll get more and may pay less, especially when you fill at a preferred cost-sharing mail-order pharmacy.

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

**Deductible** You may pay **\$0** or **\$89** depending on your level of Extra Help for Tier 4, Tier 5. If your deductible is **\$89**, you pay the full cost of these drugs until you reach **\$89**. Then, you only pay your cost-share.

### Pharmacy cost-sharing

	<b>30-day supply</b>	<b>90-day supply</b>
For generic drugs (including brand drugs treated as generic), either:	\$0 copay; or \$1.30 copay; or \$3.60 copay; or 15% of the cost	\$0 copay; or \$1.30 copay; or \$3.60 copay; or 15% of the cost
For all other drugs, either:	\$0 copay; or \$3.90 copay; or \$8.95 copay; or 15% of the cost	\$0 copay; or \$3.90 copay; or \$8.95 copay; or 15% of the cost

Other pharmacies are available in our network. \*Some drugs are limited to a 30-day supply.

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, 2019 - Mar. 31, 2020 and Monday through Friday the rest of the year.

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



## 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 identity, 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 the Office for Civil Rights Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or by mail or phone 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>**.

## 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'k'eh saad bee áká'ánída'áwo'déé nika'adoowoł.

**العربية (Arabic)**

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك