2018

Summary of Benefits

Optional Supplemental Benefits

Humana Gold Plus®
H3533-020 (HMO)

Southern Tier New York
Southern Tier Area

Our service area includes the following county/counties in New York: Broome, Chemung, Steuben, Tioga.

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Let's talk about **Humana Gold Plus® H3533-020 (HMO)**

Find out more about the Humana Gold Plus H3533-020 (HMO) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus H3533-020 (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" or you will receive one after you enroll.

To be eligible

To join Humana Gold Plus H3533-020 (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 H3533-020 (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 - February 14:
Call 7 days a week from 8 a.m. - 8 p.m.

February 15 - September 30:
Call Monday - Friday, 8 a.m. - 8 p.m.

Or visit our website:
Humana.com/medicare.

As a member you must select an in-network doctor to act as your Primary Care Provider (PCP). Humana Gold Plus H3533-020 (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!

This document is available in other formats such as Braille and large print.
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Póngase en contacto con un agente de ventas certificado de Humana al 1-800-833-2364 (TTY: 711).

Monthly Premium, Deductible and Limits

Monthly premium	**$0** You must keep paying your Medicare Part B premium.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	**$200** only applies to Tier 3,Tier 4,Tier 5.
Maximum out-of-pocket responsibility	**$6,700** 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	**$350** copay per day for days 1-5 **$0** copay per day for days 6-90 Your plan covers an unlimited number of days for an inpatient stay.
Outpatient hospital coverage	• Surgery Services at Outpatient Hospital **$350** copay • Surgery Services at Ambulatory Surgical Center **$245** copay
Doctor visits	• Primary care provider: **$5** copay • Specialist: **$45** copay

You do not need a referral to receive covered services from providers. 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 prior authorization from the plan.

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 **Any additional preventive services approved by Medicare during the contract year will be covered.**
EMERGENCY CARE	
Emergency room	**$80** 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	**$25** 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: **$45** to **$75** copay • Diagnostic radiology: **$5** to **$350** copay • Lab services: **$0** to **$25** copay • Diagnostic tests and procedures: **$0** to **$95** copay • Outpatient X-rays: **$5** to **$95** copay • Radiation therapy: **20%** of the cost
Hearing	Medicare covered hearing exam: **$45** copay
Dental	Medicare covered dental services: **$45** copay Additional dental benefits are available with a separate monthly premium. Please see the "Optional Supplemental Benefits" page for details.

You do not need a referral to receive covered services from providers. 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 prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

Vision	• Medicare-covered vision services: **$45** copay • Diabetic eye exam: **$0** copay • Glaucoma screening: **$0** copay • Eyewear (post-cataract): **$0** copay **Routine vision:** • **$0** copayment for routine exam, refraction up to 1 per year. • **$100** maximum benefit coverage amount per year for contact lenses or eyeglasses - lenses and frames (includes fitting). Eyeglasses will include ultraviolet protection and scratch resistant coating.
Mental health services	**Inpatient:** • **$300** copay per day for days 1-5 • **$0** copay per day for days 6-90 • 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): **$40** to **$70** copay Cost share may vary depending on where service is provided.
Skilled nursing facility (SNF)	• **$0** copay per day for days 1-20 • **$167.50** copay per day for days 21-100 • Your plan covers up to 100 days in a SNF
Physical Therapy	• **$40** copay
ADDITIONAL BENEFITS	
Ambulance (ground)	**$265** per date of service
Transportation	Not covered

Prescription Drug Benefits

Medicare Part B drugs	• Chemotherapy drugs: **20%** of the cost • Other Part B drugs: **20%** of the cost
PRESCRIPTION DRUGS	

Pharmacy (Part D) Deductible
$200 only applies to Tier 3,Tier 4,Tier 5.

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach $3,750. Total yearly drug costs are the total drug costs paid by both you and our plan.

You do not need a referral to receive covered services from providers. 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 prior authorization from the plan.

	Preferred Retail Pharmacy	Standard Retail Pharmacy	Preferred Mail Order	Standard Mail Order
30-day supply				
Tier 1: Preferred Generic	**$5** copay	**$10** copay	**$5** copay	**$10** copay
Tier 2: Generic	**$12** copay	**$20** copay	**$12** copay	**$20** copay
Tier 3: Preferred Brand	**$47** copay	**$47** copay	**$47** copay	**$47** copay
Tier 4: Non-Preferred Drug	**$100** copay	**$100** copay	**$100** copay	**$100** copay
Tier 5: Specialty	**29%** of the cost	**29%** of the cost	**29%** of the cost	**29%** of the cost
90-day supply				
Tier 1: Preferred Generic	**$15** copay	**$30** copay	**$0** copay	**$30** copay
Tier 2: Generic	**$36** copay	**$60** copay	**$0** copay	**$60** copay
Tier 3: Preferred Brand	**$141** copay	**$141** copay	**$131** copay	**$141** copay
Tier 4: Non-Preferred Drug	**$300** copay	**$300** copay	**$290** copay	**$300** copay

Specialty drugs are limited to a 30 day supply.

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 our "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 medicine 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 **35 percent** of the plan's cost for covered brand name drugs and **44 percent** of the plan's cost for covered generic drugs until your costs total **$5,000** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$5,000**, you pay the greater of:

- **5%** of the cost, or
- **$3.35** copay for generic (including brand drugs treated as generic) and a **$8.35** copayment for all other drugs

Additional benefits

Medicare covered foot care (podiatry)	**$45** 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	• Physical, occupational and speech therapy: **$40** copay • Cardiac rehabilitation: **$30** copay • Pulmonary rehabilitation: **$30** copay

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

HMO travel benefit
Care from an in-network HMO provider while traveling in select counties in Florida.

Meals
Well Dine Meal Program - Humana's meal program for members following an inpatient stay in the hospital or nursing facility

HumanaFirst nurse advice line
Health advice from a registered nurse, available 24 hours a day, seven days a week.

Over-the-counter (OTC) allowance
Up to **$50** every 3 months for the purchase of OTC supplies from Humana Pharmacy mail delivery.

Web/Phone based technologies
Access to doctors and other healthcare providers via phone and/or video technology for diagnosis and treatment of certain non-emergency medical issues. You pay a **$10** copay to receive a remote medical consultation.

Go365™ by Humana
Rewards for completing preventive health screenings and health and wellness activities.

Fitness benefit
SilverSneakers® Fitness Program – Basic fitness center membership including fitness classes.

Optional **Supplemental Benefits**

Customize your coverage for an extra monthly premium when you enroll. You can choose from the following to help create your Medicare plan.

$23.10

MyOption Platinum Dental
Offers coverage for preventive, basic, and major services with both in- and out-of-network dentists. These extra benefits have an additional monthly premium.

Humana MyOption optional supplemental benefits (OSB) are only available to members of certain Humana Medicare Advantage (MA) plans. Members of Humana plans that offer OSBs may enroll in OSBs throughout the year. Benefits may change on January 1 each year. Enrollees must use network providers for specific OSBs when stated in the Evidence of Coverage (EOC); otherwise, covered services may be received from non-network providers at a higher cost. Enrollees must continue to pay the Medicare Part B premium, their Humana plan premium and the OSB premium.

Find out **more**

You can see our plan's **provider and pharmacy directory** at our website at **www.humana.com/members/tools** 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 formulary** at our website at **www.humana.com/medicare/medicare_prescription_drugs/medicare_drug_tools/medicare_drug_list/** or call us at the number listed at the beginning of this booklet and we will send you one.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

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.

The provider/pharmacy network may change at any time. You will receive notice when necessary.

Limitations on healthcare and prescription services delivered via remote access technology and communications options vary by state. Remote access technology services are not a substitute for emergency care and not intended to replace your primary care provider or other providers in your network. This material is provided for informational use only and should not be construed as medical advice or used in place of consulting a licensed medical professional.

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Optional Supplemental Benefits

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Southern Tier New York
Southern Tier Area

Humana®

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My Options, My Choice
Adding Benefits to Your Plan

You're unique and have unique needs. That's why Humana offers optional supplemental benefits (OSB). For an extra monthly premium you can customize your Humana Medicare Advantage plan.

You can add these extra benefits when you sign up for your Medicare Advantage plan or any time during the year.

The information in this booklet will tell you about the benefits you can add to your plan. If you have questions, you can call us at 1-888-866-3154 (TTY: 711). We are available seven days a week, from 8 a.m. - 8 p.m. local time. However, please note that our automated phone system may answer your call during weekends and holidays from February 15 - September 30. Please leave your name and telephone number, and we will call you back by the end of the next business day.

MyOption℠ Platinum Dental

The MyOption℠ Platinum Dental benefit helps you plan for your dental care. This benefit has no deductible and pays the full cost for two routine exams per year with an in-network provider.

Here's how the benefit works:

Monthly Premium	**$23.10**		
Annual Deductible	There is no annual deductible for all services		
Maximum Benefit	Humana pays up to **$2,000** per calendar year		
Covered Dental Services	**In-Network* You Pay**	**Out-Of-Network** You Pay**	**Benefit Limitations Per Calendar Year**
Preventive and Diagnostic Dental Services			
Oral examinations	**0%**	**50%**	Two per year
Cancer screening	**0%**	**50%**	One per year
Emergency exam	**0%**	**50%**	Two per year
Dental prophylaxis (cleanings)	**0%**	**50%**	Two per year
Bitewing X-ray	**0%**	**50%**	One set per year
Basic Dental Services (Minor Restorative)			
Amalgam restorations (silver fillings)	**0%**	**50%**	Two per year
Composite resin restorations (white fillings)	**0%**	**50%**	
Extractions (pulling teeth), nonsurgical and surgical	**50%**	**55%**	Two per year
Crown or bridge re-cement	**50%**	**55%**	One per year

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations Per Calendar Year
Basic Dental Services (Minor Restorative)			
Emergency treatment for pain	**50%**	**55%**	Two per year
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Root canal treatment	**70%**	**75%**	One per year
Crowns	**70%**	**75%**	One per year
Periodontal scaling and root planing (deep cleaning)	**70%**	**75%**	One procedure for each quadrant every three years
Periodontal maintenance	**70%**	**75%**	Two per year
Complete dentures (including routine post-delivery care)	**70%**	**75%**	One upper and/or one lower complete denture every five years
Partial dentures	**70%**	**75%**	One upper and/or one lower partial denture every five years
Denture adjustments (not covered within six months of initial placement)	**70%**	**75%**	One per year
Denture reline (not allowed on spare dentures)	**70%**	**75%**	One per year
Restoration implant services	**70%**	**75%**	One per year

Covered dental services are subject to conditions, limitations, exclusions, and maximums. Please see your Evidence of Coverage for details.

*Network dentists have agreed to provide services at an in-network rate. If you see a network dentist, you can't be billed more than the in-network rate.

**If you see an out-of-network dentist, your share of the cost may be higher.

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Notes

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Notes

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- 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.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-800-281-6918 or if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512 - 4618

If you need help filing a grievance, call 1-800-281-6918 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-800-281-6918 (TTY: 711)**.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-281-6918 (TTY: 711)**.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-281-6918**（**TTY: 711**）。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-281-6918 (TTY: 711)**.

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . **1-800-281-6918 (TTY: 711)** 번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-281-6918 (TTY: 711)**.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-281-6918 (телетайп: 711)**.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-281-6918 (TTY: 711)**.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-281-6918 (ATS : 711)**.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-800-281-6918 (TTY: 711)**.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-281-6918 (TTY: 711)**.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-281-6918 (TTY: 711)**.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-281-6918 (TTY: 711)**.

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-281-6918**（**TTY：711**）まで、お電話にてご連絡ください。

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-281-6918 (TTY: 711)** تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hółǫ́, kojį' hódíílnih **1-800-281-6918 (TTY: 711)**.

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-281-6918** (هاتف الصُم: **711**).

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