MEDICARE ADVANTAGE / PDP

Plan Details

Humana

$29.00

Plan: **HumanaChoice H5216-186 (PPO)**

Max Out of Pocket: **$6,700**

Annual Drug Deductible: **$250.00**

ID: **H5216-186-0**

Star Rating: **4.0**

Plan Type: **Local PPO**

Part B Reduction: **No**

Effective Year: **2021**

City: **CAMDEN**

State: **NJ**

Zip: **08104**

Chiropractic care

Out of Network: 20% coinsurance.

In Network: Not covered. $20 copay for Medicare-covered visits.

Dental services

Out of Network: 50% coinsurance. (Preventive Dental)

Out of Network: 20% coinsurance. (Comprehensive Dental)

Out of Network: 55-75% coinsurance. (Comprehensive Dental)

In Network: $35 copay for Medicare-covered services.0% coinsurance for prophylaxis (cleaning). 0% coinsurance for oral exams. 0% coinsurance for fluoride treatment. 0% coinsurance for dental x-rays. Prophylaxis max of 2 every year. Oral exam max of 3 (see carrier information for details). Fluoride max of 2 every year. Xray max of 3 (see carrier information for details). Max of $2000 combined preventive and comprehensive dental benefits for this plan every year.

Diabetes supplies and services

Out of Network: 20% coinsurance.

In Network: $0 copay for diabetes self-management training.

In Network: 10-20% coinsurance for Medicare-covered diabetes supplies and services. or $0 copay for Medicare-covered diabetes supplies and services. $0 copay for therapeutic shoes or inserts.

Diagnostic tests lab and radiology services and x-rays (Costs for these services may be different if received in an outpatient surgery setting)

Out of Network: 20% coinsurance. or $0 copay. (Diagnostic Procedures/Tests)

Out of Network: 20% coinsurance. or $0 copay. (Lab Services)

Out of Network: 20% coinsurance. (Diagnostic Radiological Services)

Out of Network: 20% coinsurance. (Therapeutic Radiological Services)

Out of Network: 20% coinsurance. (Outpatient X-Ray Services)

In Network: 20% coinsurance for Medicare-covered diagnostic radiological services (e.g., CT, MRI, etc). or 20% coinsurance for other Medicare-covered therapeutic radiological services. $0-105 copay for Medicare-covered diagnostic procedures/tests. $0-35 copay for Medicare-covered lab services. $35-275 copay for Medicare-covered diagnostic radiological services (e.g., CT, MRI, etc). $5-95 copay for Medicare-covered x-rays.

Doctor's office visits

Out of Network: 20% coinsurance. (Primary Care Physician Services)

Out of Network: 20% coinsurance. (Physician Specialist Services)

In Network: Primary Physician: $5 copay Specialist Physician: $35 copay

Durable medical equipment (wheelchairs oxygen etc.)

Out of Network: 20% coinsurance.

In Network: 20% per item

Foot care (podiatry services)

Out of Network: 20% coinsurance.

In Network: $35 copay for Medicare-covered visits.

Hearing services

Out of Network: $0 copay. (Hearing Exams)

Out of Network: 20% coinsurance. (Hearing Exams)

Out of Network: $199-499 copay. (Hearing Aids)

In Network: $199-499 copay for hearing aids (all types). Hearing aid max of 2 every year. $0 copay for fitting/evaluation for hearing aid. Fitting max of 1 every year. $0 copay for routine hearing exams. Routing hearing exam max of 1 every year.

Home health care

Out of Network: $0 copay.

In Network: $0 copay

Mental health care

Out of Network: 20% coinsurance.

Out of Network: 20% coinsurance for stay

In Network: $275 copay for days 1-5 $0 copay for days 6-90

Outpatient rehabilitation

Out of Network: 20% coinsurance. (Cardiac Rehabilitation Services)

Out of Network: 20% coinsurance. (Intensive Cardiac Rehabilitation Services)

Out of Network: 20% coinsurance. (Pulmonary Rehabilitation Services)

Out of Network: 20% coinsurance. (Occupational Therapy Services)

Out of Network: 20% coinsurance. (Physical Therapy and Speech-Language Pathology Services)

In Network: $10 copay for Medicare-covered cardiac rehabilitation services. $10 copay for Medicare-covered intensive cardiac rehabilitation services. $10 copay for Medicare-covered pulmonary rehabilitation services.

In Network: $5-40 copay for physical therapy and speech therapy. $5-40 copay for occupational therapy.

Outpatient substance abuse

Out of Network: 20% coinsurance.

In Network: $35-95 copay for group visits. $35-95 copay for individual visits.

Outpatient surgery

Out of Network: 20% coinsurance. (Ambulatory Surgical Center (ASC) Services)

In Network: $35-275 per visit

Over-the-counter items

Out of Network: 50% coinsurance. Plan benefit max of $50.

In Network: Max of $50 benefit for this plan every three months. Not all medications of the OTC list in Chapter 4 of Medicare Managed Care Manual are included.

Prosthetic devices (braces artificial limbs etc.)

Out of Network: 20% coinsurance.

In Network: 20% coinsurance for Medicare-covered medical supplies. 20% coinsurance for Medicare-covered prosthetic devices.

Renal dialysis

Out of Network: 20% coinsurance.

In Network: 20% per visit

Transportation

Out of Network: 50% coinsurance.

In Network: $0 copay. Max of 12 trips to plan-approved locations every year. Covered modes of transportation include van to plan approved locations.

Vision services

Out of Network: $0 copay. (Eye Exams)

Out of Network: 20% coinsurance. (Eye Exams)

Out of Network: $0 copay. (Eyewear)

In Network: $0 copay for contacts. Contacts max of 1 every year. $0 copay for glasses. Glasses max of 1 every year. $0 copay for routine eye exams. Routine eye exam max of 1 every year. $0-35 copay for Medicare-covered eye exams. $0 copay for Medicare-covered eye wear. Max of $200 combined benefit for this plan every year. Max of $75 benefit for this plan for routine eye exams every year.

Preventive care

Out of Network: $0 copay.

In Network: Annual physical exam covered. $0 copay for annual physical exam. Supplemental benefits available, see carrier site for more detailed information.

Outpatient prescription drugs

Out of Network: 20% coinsurance.

In Network: 20% coinsurance for chemo drugs.20% coinsurance for prescriptions.

Tier 1 (Preferred Generic)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	$2	Not Offered	$6
Standard Retail:	$10	Not Offered	$30
Preferred Mail Order:	$2	Not Offered	$0
Standard Mail Order:	$10	Not Offered	$30

Tier 2 (Generic)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	$8	Not Offered	$24
Standard Retail:	$20	Not Offered	$60
Preferred Mail Order:	$8	Not Offered	$0
Standard Mail Order:	$20	Not Offered	$60

Tier 3 (Preferred Brand)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	$47	Not Offered	$141
Standard Retail:	$47	Not Offered	$141
Preferred Mail Order:	$47	Not Offered	$131
Standard Mail Order:	$47	Not Offered	$141

Tier 4 (Non-Preferred Drug)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	$100	Not Offered	$300
Standard Retail:	$100	Not Offered	$300
Preferred Mail Order:	$100	Not Offered	$290
Standard Mail Order:	$100	Not Offered	$300

Tier 5 (Specialty Tier)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	28%	Not Offered	Not Offered
Standard Retail:	28%	Not Offered	Not Offered
Preferred Mail Order:	28%	Not Offered	Not Offered
Standard Mail Order:	28%	Not Offered	Not Offered

Inpatient hospital care

Out of Network: 20% coinsurance for stay

In Network: $275 copay for days 1-5 $0 copay for days 6-90 Benefit continues for unlimited days of hospital stay.

Skilled Nursing Facility (SNF)

Out of Network: 20% coinsurance for stay

In Network: $0 copay for days 1-20 $184 copay for days 21-100

Monthly premium deductible and limits on how much you pay for covered services

$10000 in and out-of-network out of pocket maximum. $6700 in-network out of pocket maximum.

Acupuncture

Not covered

Ambulance

$290 copay

Emergency care

$90 per visit, waived if admitted within 24 hours. Maximum $90 per visit.

Hospice

You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.

Urgently needed services

20% coinsurance. Maximum $65 per visit. or $5-35 copay. Maximum $65 per visit.