Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
PLAN COSTS		
Monthly premium You must keep paying your Medicare Part B premium.	For information concerning the actual premiums you will pay, please contact your employer group benefits plan administrator.	
Medical deductible	**$28** per year for some combined in- and out-of-network services	**$28** per year for some combined in- and out-of-network services
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for medical services for the year.	**In-Network Maximum Out-of-Pocket** **$2,500** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Podiatry Services (Routine); Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Transportation (Routine); Vision Services (Routine) and the Plan Premium do not apply to the in-network maximum out-of-pocket. If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.	**Combined In and Out-of-Network Maximum Out-of-Pocket** **$2,500** out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy; Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Podiatry Services (Routine); Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Transportation (Routine); Vision Services (Routine) and the Plan Premium do not apply to the combined maximum out-of-pocket. Out-of-Network Exclusions: Part D Pharmacy; Hearing Services (Routine); Podiatry Services (Routine); Transportation (Routine); Vision Services (Routine); Worldwide Coverage and the Plan Premium do not apply to the combined maximum out-of-pocket. Your limit for services received from in-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
This plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**$320** per admit	**$320** per admit
OUTPATIENT HOSPITAL COVERAGE		
Outpatient hospital visits	**0%** to **4%** of the cost	**0%** to **4%** of the cost
Observation services	**4%** of the cost	**4%** of the cost
Ambulatory surgical center	**4%** of the cost	**4%** of the cost
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**4%** of the cost	**4%** of the cost
Specialists	**4%** of the cost	**4%** of the cost
PREVENTIVE CARE		
Including: Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Any additional preventive services approved by Medicare during the contract year will be covered.	**Covered at no cost**	**Covered at no cost**
EMERGENCY CARE		
Emergency room If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	**4%** of the cost for Medicare-covered emergency room visit(s)	**4%** of the cost for Medicare-covered emergency room visit(s)
Urgently needed services Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**4%** of the cost	**4%** of the cost
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic radiology	**0%** to **4%** of the cost	**0%** to **4%** of the cost
Lab services	**0%** of the cost	**0%** of the cost

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
Diagnostic tests and procedures	**0%** to **4%** of the cost	**0%** to **4%** of the cost
Outpatient x-rays	**4%** of the cost	**4%** of the cost
Radiation therapy	**0%** to **4%** of the cost	**0%** to **4%** of the cost
HEARING SERVICES		
Medicare-covered hearing: diagnostic hearing and balance exams	**4%** of the cost	**4%** of the cost
Routine hearing TruHearing Provider must be used. Contact Customer Service to locate a provider.	**$0** copay for routine hearing exams up to 1 per year. **$2,000** maximum benefit coverage amount for hearing aid(s) (all types) up to 2 per year. Note: Includes 80 batteries per aid and 3 year warranty.	
DENTAL SERVICES		
Medicare-covered dental	**4%** of the cost (services include surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease)	**4%** of the cost (services include surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease)
VISION SERVICES		
Medicare-covered vision services	**0%** of the cost (services include diagnosis and treatment of diseases and injuries of the eye)	**0%** of the cost (services include diagnosis and treatment of diseases and injuries of the eye)
Medicare-covered diabetic eye exam (1 per year)	**0%** of the cost	**0%** of the cost
Medicare-covered glaucoma screening (1 per year)	**0%** of the cost	**0%** of the cost
Medicare-covered eyewear (post-cataract)	**0%** of the cost	**0%** of the cost
Routine vision EyeMed is the In-Network provider for the routine vision benefit. Contact Customer Service to locate a provider.	**$0** copay for routine exam (includes refraction) up to 1 per year. **$250** combined maximum benefit coverage amount per year for contact lenses, eyeglasses (lenses and frames), including lens options such as ultraviolet protection and scratch resistant	**$175** combined maximum benefit coverage amount per year for routine exam (includes refraction). **$0** copay for routine exam (includes refraction) up to 1 per year. **$250** combined maximum benefit coverage amount per year for contact lenses, eyeglasses (lenses and frames), including lens options

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	IN-NETWORK	OUT-OF-NETWORK
	coating, fitting for eyeglasses (lenses and frames).	such as ultraviolet protection and scratch resistant coating, fitting for eyeglasses (lenses and frames). Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
MENTAL HEALTH SERVICES		
Inpatient The inpatient hospital care limit applies to inpatient mental services provided in a general hospital or a psychiatric facility. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. 190 day lifetime limit in a psychiatric facility.	**$320** per admit	**$320** per admit
Outpatient group and individual therapy visits	**Outpatient therapy visit:** **0%** to **4%** of the cost **Partial Hospitalization:** **4%** of the cost	**Outpatient therapy visit:** **0%** to **4%** of the cost **Partial Hospitalization:** **4%** of the cost
SKILLED NURSING FACILITY		
This plan covers up to 100 days in a SNF. No 3-day hospital stay is required. Plan pays $0 after 100 days.	**$0** copay per day for days 1-20 **$40** copay per day for days 21-100	**$0** copay per day for days 1-20 **$40** copay per day for days 21-100
PHYSICAL THERAPY		
	4% of the cost	**4%** of the cost
AMBULANCE		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	**4%** of the cost	**4%** of the cost
TRANSPORTATION		
	$0 copay for plan approved location up to 24 one-way trip(s) per year. This benefit is not to exceed 50 miles per trip.	

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
PART B PRESCRIPTION DRUGS		
Medicare Part B covered drugs	**4%** of the cost	**4%** of the cost
Medicare Part B insulin drugs You will pay no more than $35 for a one-month (up to 30-day) supply for all Part B insulin covered by our plan, and if your plan has a deductible it does not apply to Part B insulin.	**4%** of the cost	**4%** of the cost
ACUPUNCTURE SERVICES		
Medicare-covered acupuncture visit(s) for chronic low back pain This plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements.	**4%** of the cost for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year.	**4%** of the cost for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
ALLERGY		
Allergy shots & serum	**4%** of the cost	**4%** of the cost
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	**4%** of the cost	**4%** of the cost
DIABETES MANAGEMENT TRAINING		
	0% of the cost	**0%** of the cost
FOOT CARE (PODIATRY)		
Medicare-covered foot care	**4%** of the cost	**4%** of the cost
Routine foot care	**$0** copay for routine podiatry visits up to 6 combined in and out of network visit(s) per year.	**$0** copay for routine podiatry visits up to 6 combined in and out of network visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
HOME HEALTH CARE		
	0% of the cost	**0%** of the cost
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**4%** of the cost	**4%** of the cost

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
Medical supplies (includes but not limited to: catheters, IV set-up and supplies)	**0%** of the cost	**0%** of the cost
Prosthetics (artificial limbs or braces)	**4%** of the cost	**4%** of the cost
Diabetes monitoring supplies	**0%** to **4%** of the cost	**0%** to **4%** of the cost
Continuous glucose monitors	**4%** of the cost	**4%** of the cost
OUTPATIENT SUBSTANCE ABUSE		
Outpatient group and individual substance abuse treatment visits	**Outpatient therapy visit:** **0%** to **4%** of the cost **Partial Hospitalization:** **4%** of the cost	**Outpatient therapy visit**: **0%** to **4%** of the cost **Partial Hospitalization:** **4%** of the cost
REHABILITATION SERVICES		
Occupational and speech therapy	**4%** of the cost	**4%** of the cost
Cardiac rehabilitation	**4%** of the cost	**4%** of the cost
Pulmonary rehabilitation	**4%** of the cost	**4%** of the cost
RENAL DIALYSIS		
Renal dialysis	**4%** of the cost	**4%** of the cost
Kidney disease education services	**0%** of the cost	**0%** of the cost
HUMANA IN-NETWORK TELEHEALTH VENDORS, i.e. MDLive (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered
Specialist	**4%** of the cost	Not Covered
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
FITNESS AND WELLNESS		
	Live a healthier, more active life through fitness and social connection at participating SilverSneakers ® locations and online.	
HEALTH EDUCATION SERVICES		
	Personal Health Coaching is an interactive inbound and outreach on-line and telephonic wellness coaching for Medicare participants who elect to participate, for wellness improvement, including weight management, nutrition, exercise, back care, blood pressure management, and blood sugar management.	
MEAL BENEFIT		
	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members are eligible for nutritious meals delivered to their door at no cost.	
POST-DISCHARGE PERSONAL HOME CARE		
	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members may receive assistance performing activities of daily living within the home. Types of assistance include bathing, dressing, toileting, walking, eating and preparing meals.	
POST-DISCHARGE TRANSPORTATION SERVICES		
	After a member’s overnight inpatient stay in a hospital or skilled nursing facility, members are provided transportation to plan approved locations by rideshare services, car, van or wheelchair accessible vehicle at no cost.	
SMOKING CESSATION (ADDITIONAL)		
	A comprehensive smoking cessation program available online, email and phone. Personal coaches assist via establishing goals and providing articles and resources to aid in the effort to quit smoking.	
HOSPICE You must get care from a Medicare-certified hospice. You must consult with this plan before you select hospice.		

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