Monthly Premium, Deductible and Limits

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
Medical 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); Uniform Flexibility Non-Emergency Medical Transportation; 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); Uniform Flexibility Non-Emergency Medical Transportation; 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: *This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: Humana.com/PAL.*

Covered Medical 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		
Diagnostic colonoscopy	**4%** of the cost	**4%** of the cost
Diagnostic mammography	**4%** of the cost	**4%** of the cost
Observation services	**4%** of the cost	**4%** of the cost
Surgery services	**4%** of the cost	**4%** of the cost
AMBULATORY SURGICAL CENTER		
Diagnostic colonoscopy	**4%** of the cost	**4%** of the cost
Surgery services	**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

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE		
This plan covers all Medicare preventative services including: • Abdominal aortic aneurysm screening • Alcohol misuse screening & counseling • Annual wellness visit • Bone mass measurement • Breast cancer screening • Cardiovascular disease behavioral therapy • Cardiovascular disease screening • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes self-management training • Diabetes screening • Glaucoma screening • Hepatitis C screening • HIV screening • Kidney disease education services • Lung cancer screening • Medical nutrition therapy • Obesity screening and therapy • Physical exams (routine) • Prostate cancer screening exam • Smoking and tobacco use cessation • STI screening and counseling • "Welcome to Medicare" preventative visit	**Covered at no cost**	**Covered at no cost**
• Immunizations • Medicare diabetes prevention program (MDPP) Any additional preventative services approved by Medicare during the contract year will be covered.	**Covered at no cost**	**Covered at no cost**

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
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		
• Primary care provider (PCP)	**4%** of the cost	**4%** of the cost
• Specialist's office	**4%** of the cost	**4%** of the cost
• Urgent care center	**4%** of the cost	**4%** of the cost
Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.		
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Advanced imaging services (MRI, MRA, PET and CT Scan)		
• Primary care provider (PCP)	**4%** of the cost	**4%** of the cost
• Specialist's office	**0%** of the cost	**0%** of the cost
• Freestanding radiological facility	**4%** of the cost	**4%** of the cost
• Outpatient Hospital	**4%** of the cost	**4%** of the cost
Diagnostic mammography		
• Primary care provider (PCP)	**4%** of the cost	**4%** of the cost
• Specialist's office	**4%** of the cost	**4%** of the cost
• Freestanding radiological facility	**4%** of the cost	**4%** of the cost
• Outpatient Hospital	**4%** of the cost	**4%** of the cost
Diagnostic procedures and tests		
• Primary care provider (PCP)	**4%** of the cost	**4%** of the cost
• Specialist's office	**4%** of the cost	**4%** of the cost
• Urgent care center	**4%** of the cost	**4%** of the cost
• Freestanding radiological facility	**4%** of the cost	**4%** of the cost
• Outpatient Hospital	**4%** of the cost	**4%** of the cost
EKG screening		
• Primary care provider (PCP)	**0%** of the cost	**0%** of the cost
• Specialist's office	**0%** of the cost	**0%** of the cost

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	IN-NETWORK	OUT-OF-NETWORK
• Freestanding radiological facility	**0%** of the cost	**0%** of the cost
• Outpatient Hospital	**0%** of the cost	**0%** of the cost
Lab services		
• Primary care provider (PCP)	**0%** of the cost	**0%** of the cost
• Specialist's office	**0%** of the cost	**0%** of the cost
• Urgent care center	**0%** of the cost	**0%** of the cost
• Freestanding laboratory	**0%** of the cost	**0%** of the cost
• Outpatient Hospital	**0%** of the cost	**0%** of the cost
Nuclear medicine services		
• Freestanding radiological facility	**4%** of the cost	**4%** of the cost
• Outpatient Hospital	**4%** of the cost	**4%** of the cost
Outpatient x-rays		
• Primary care provider (PCP)	**4%** of the cost	**4%** of the cost
• Specialist's office	**4%** of the cost	**4%** of the cost
• Urgent care center	**4%** of the cost	**4%** of the cost
• Freestanding radiological facility	**4%** of the cost	**4%** of the cost
• Outpatient Hospital	**4%** of the cost	**4%** of the cost
Radiation therapy		
• Specialist's office	**4%** of the cost	**4%** of the cost
• Freestanding radiological facility	**0%** of the cost	**0%** of the cost
• Outpatient Hospital	**0%** of the cost	**0%** 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.	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
DENTAL SERVICES		
Medicare-covered dental	**4%** of the cost	**4%** of the cost
VISION SERVICES		
Medicare-covered vision services	**0%** of the cost	**0%** of the cost

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	IN-NETWORK	OUT-OF-NETWORK
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 coating, fitting for eyeglasses (lenses and frames).	**$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 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
Partial Hospitalization	**4%** of the cost	**4%** of the cost
Intensive Outpatient Services	**4%** of the cost	**4%** of the cost
Outpatient group and individual therapy visits		
• Primary care provider (PCP)	**4%** of the cost	**4%** of the cost
• Specialist's office	**0%** of the cost	**0%** of the cost
• Urgent care	**4%** of the cost	**4%** of the cost
• Outpatient Hospital	**0%** of the cost	**0%** of the cost

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
SKILLED NURSING FACILITY (SNF)		
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
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		
Routine 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.	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges
Uniform Flexibility Non-Emergency Medical Transportation	**$0** copay for plan approved location up to unlimited one-way trip(s) per year by car, rideshare services, van, wheelchair access vehicle for members with a Chronic Kidney Disease (CKD), End Stage Renal Disease (ESRD), or Cancer Diagnosis. This benefit is not to exceed 50 miles per trip.	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
MEDICARE PART B PRESCRIPTION DRUGS		
Chemotherapy drugs		
• Specialist's office	**4%** of the cost	**4%** of the cost
• Outpatient Hospital	**4%** of the cost	**4%** of the cost
Medicare Part B covered drugs		
• Primary care provider (PCP)	**4%** of the cost	**4%** of the cost
• Specialist's office	**4%** of the cost	**4%** of the cost
• Outpatient Hospital	**4%** of the cost	**4%** of the cost
• Pharmacy	**4%** of the cost	**4%** of the cost
Medicare Part B insulin drugs		
• Primary care provider (PCP)	**4%** of the cost	**4%** of the cost
• Specialist's office	**4%** of the cost	**4%** of the cost

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	IN-NETWORK	OUT-OF-NETWORK
• Outpatient Hospital	**4%** of the cost	**4%** of the cost
• Pharmacy	**4%** of the cost	**4%** of the cost
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.		
ACUPUNCTURE SERVICES		
Medicare-covered acupuncture visit(s) for chronic low back pain	**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		
• Primary care provider (PCP)	**4%** of the cost	**4%** of the cost
• Specialist's office	**4%** of the cost	**4%** of the cost
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	**4%** of the cost	**4%** of the cost
DIABETES SERVICES AND SUPPLIES		
Continuous glucose monitor (CGM)		
• Durable medical equipment provider	**4%** of the cost	**4%** of the cost
• Pharmacy	**4%** of the cost	**4%** of the cost
Diabetes management training		
• Primary care provider (PCP)	**0%** of the cost	**0%** of the cost
• Specialist's office	**0%** of the cost	**0%** of the cost
• Outpatient hospital	**0%** of the cost	**0%** of the cost
Diabetes monitoring supplies		
• Durable medical equipment provider	**4%** of the cost	**4%** of the cost
• Pharmacy	**0%** of the cost	**0%** of the cost
• Preferred diabetic supplier	**$0** copay	Not Covered
Diabetes screening		
• Primary care provider (PCP)	**0%** of the cost	**0%** of the cost
• Specialist's office	**0%** of the cost	**0%** of the cost

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
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
HOSPICE You must get care from a Medicare-certified hospice. You must consult with this plan before you select hospice.		
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment		
• Durable medical equipment provider	**4%** of the cost	**4%** of the cost
• Pharmacy	**4%** of the cost	**4%** of the cost
Medical supplies (includes but not limited to: catheters, IV set-up and supplies)		
• Medical supply provider	**0%** of the cost	**0%** of the cost
• Pharmacy	**0%** of the cost	**0%** of the cost
Prosthetics (artificial limbs or braces)		
• Prosthetics provider	**4%** of the cost	**4%** of the cost
OUTPATIENT SUBSTANCE ABUSE		
Outpatient group and individual substance abuse treatment visits		
• Primary care provider (PCP)	**4%** of the cost	**4%** of the cost
• Specialist's office	**0%** of the cost	**0%** of the cost
• Urgent care	**4%** of the cost	**4%** of the cost
• Outpatient hospital	**0%** of the cost	**0%** of the cost
REHABILITATION SERVICES		
Audiology Therapy		
• Specialist's office	**4%** of the cost	**4%** of the cost

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	IN-NETWORK	OUT-OF-NETWORK
• Comprehensive outpatient rehab facility	**4%** of the cost	**4%** of the cost
• Outpatient hospital	**4%** of the cost	**4%** of the cost
Cardiac rehabilitation		
• Specialist's office	**4%** of the cost	**4%** of the cost
• Outpatient hospital	**4%** of the cost	**4%** of the cost
Occupational therapy		
• Specialist's office	**4%** of the cost	**4%** of the cost
• Comprehensive outpatient rehab facility	**4%** of the cost	**4%** of the cost
• Outpatient hospital	**4%** of the cost	**4%** of the cost
Physical therapy		
• Specialist's office	**4%** of the cost	**4%** of the cost
• Comprehensive outpatient rehab facility	**4%** of the cost	**4%** of the cost
• Outpatient hospital	**4%** of the cost	**4%** of the cost
Pulmonary rehabilitation		
• Specialist's office	**4%** of the cost	**4%** of the cost
• Comprehensive outpatient rehab facility	**4%** of the cost	**4%** of the cost
• Outpatient hospital	**4%** of the cost	**4%** of the cost
Speech therapy		
• Specialist's office	**4%** of the cost	**4%** of the cost
• Comprehensive outpatient rehab facility	**4%** of the cost	**4%** of the cost
• Outpatient hospital	**4%** of the cost	**4%** of the cost
RENAL DIALYSIS		
Renal dialysis services		
• Dialysis center	**4%** of the cost	**4%** of the cost
• Outpatient hospital	**4%** of the cost	**4%** of the cost
Kidney disease education services		
• Primary care provider (PCP)	**0%** of the cost	**0%** of the cost
• Specialist's office	**0%** of the cost	**0%** of the cost
• Outpatient hospital	**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

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered

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Additional Benefits

FITNESS AND WELLNESS	
	Live a healthier, more active life through fitness and social connection at participating SilverSneakers® locations and online. The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
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. The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
POST-DISCHARGE SERVICES	
	$0 copay for the following benefits per discharge event following each inpatient or skilled nursing facility stay: • Assistance from a qualified aid to help perform activities of daily living within the home. Minimum of 4 hours per day, up to a maximum of 8 hours. Types of assistance include bathing, dressing, toileting, walking, eating and preparing meals. • 2 meals per day for 14 days, up to 28 meals delivered to your door. • Transportation to plan approved locations by rideshare services, car, van or wheelchair accessible vehicle. Services must be provided by approved vendors, scheduled within 30 days of discharge event and utilized within 60 days of discharge. The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
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. The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

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