Monthly Premium, Deductible and Limits

Monthly Plan Premium	$50 You must keep paying your Medicare Part B premium.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	This plan does not have a deductible.
Maximum out-of-pocket responsibility	**$2,900** 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	**$200** 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	• Outpatient surgery at Outpatient Hospital: **$175** copay • Outpatient surgery at Ambulatory Surgical Center: **$100** copay
Doctor visits	• Primary care provider: **$0** copay • Specialist: **$10** copay

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Covered Medical and Hospital Benefits (cont.)

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 • Medicare diabetes prevention program **Any additional preventive services approved by Medicare during the contract year will be covered.**
EMERGENCY CARE	
Emergency room	**$100** 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	**$10** 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: **$10** to **$50** copay • Diagnostic radiology: **$0** to **$175** copay • Lab services: **$0** copay • Diagnostic tests and procedures: **$0** to **$50** copay • Outpatient X-rays: **$0** to **$10** copay • Radiation therapy: **20%** of the cost

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Covered Medical and Hospital Benefits (cont.)

Hearing

Medicare covered hearing exam: **$10** copay

- **$0** copayment for routine hearing exams up to 1 per year.
- **$0** copayment for fitting/evaluation up to 3 per year.
- **$699** copayment for advanced level hearing aid up to 1 per ear per year.
- **$999** copayment for premium hearing aid purchase up to 1 per ear per year.
- Note: Includes 48 batteries per aid and 3 year warranty.

TruHearing provider must be used.

Dental

Medicare covered dental services: **$10** copay

The cost-share indicated below is what you pay for the covered service.

- **0%** coinsurance for periodontal exam up to 1 every 3 years.
- **0%** coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years.
- **0%** coinsurance for bitewing x-rays up to 1 set(s) per year.
- **0%** coinsurance for intraoral x-rays up to 1 per year.
- **0%** coinsurance for periodic oral exam and/or comprehensive oral evaluation, prophylaxis (cleaning) up to 2 per year.
- **0%** coinsurance for necessary anesthesia with covered service up to unlimited per year.
- **50%** coinsurance for amalgam and/or composite filling, simple or surgical extraction up to 2 per year.
- **$1000** maximum benefit coverage amount per year for amalgam and/or composite filling, bitewing x-rays, intraoral x-rays, necessary anesthesia with covered service, panoramic film or diagnostic x-rays, periodic oral exam and/or comprehensive oral evaluation, periodontal exam, prophylaxis (cleaning), simple or surgical extraction.

Use the HumanaDental Medicare network for the Mandatory Supplemental Dental. The provider locator can be found at Humana.com > Find a Doctor > from the Search Type drop down select Dental > under Coverage Type select All Dental Networks > enter zip code > from the network drop down select HumanaDental Medicare.

Additional dental benefits are available with a separate monthly premium. Please see the "Optional Supplemental Benefits" page for details.

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Covered Medical and Hospital Benefits (cont.)

Vision	• Medicare-covered vision services: **$10** copay • Diabetic eye exam: **$0** copay • Glaucoma screening: **$0** copay • Eyewear (post-cataract): **$0** copay **Routine vision: VIS734** • **$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. The provider locator can be found at Humana.com > Find a Doctor > from the Search Type drop down select Vision > Eyemed Select Network.
Mental health services	**Inpatient:** • **$900** per admit • 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): **$10** to **$100** copay Cost share may vary depending on where service is provided.
Skilled nursing facility (SNF)	• **$0** copay per day for days 1-20 • **$120** copay per day for days 21-100 • Your plan covers up to 100 days in a SNF
Physical Therapy	• **$10** copay
ADDITIONAL BENEFITS	
Ambulance (ground)	**$250** per date of service
Transportation	**$0** copay for up to 24 one-way trips to plan approved locations. Not to exceed 25 miles per trip. The member *must* contact transportation vendor to arrange transportation.

Prescription Drug Benefits

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

Deductible This plan does not have a deductible.

Initial coverage

You pay the following until your total yearly drug costs reach **$3,820**. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.

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Preferred cost-sharing

Pharmacy options	**Retail** To find the preferred cost-share retail pharmacies near you, go to		**Mail order**	
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 1: Preferred Generic	$2	$6	$2	$0
Tier 2: Generic	$10	$30	$10	$0
Tier 3: Preferred Brand	$47	$141	$47	$94
Tier 4: Non-Preferred Drug	$100	$300	$100	$200
Tier 5: Specialty Tier	33%	N/A	33%	N/A

Standard cost-sharing

Pharmacy options	**Retail** All other network retail pharmacies.		**Mail order**	
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 1: Preferred Generic	$10	$30	$10	$30
Tier 2: Generic	$20	$60	$20	$60
Tier 3: Preferred Brand	$47	$141	$47	$141
Tier 4: Non-Preferred Drug	$100	$300	$100	$300
Tier 5: Specialty Tier	33%	N/A	33%	N/A

Generic drugs may be covered on tiers other than Tier 1 and Tier 2 so please check this plan's Humana Drug List to validate the specific tier on which your drugs are covered.

Specialty drugs are limited to a 30 day supply.

ADDITIONAL DRUG COVERAGE

Erectile dysfunction (ED) drugs Covered at Tier 1 cost-share amount.

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 drug 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 **25 percent** of the plan's cost for covered brand name drugs and **37 percent** of the plan's cost for covered generic drugs until your costs total **$5,100** — 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 **$5,100**, you pay the greater of:
- **5%** of the cost, or
- **$3.40** copay for generic (including brand drugs treated as generic) and a **$8.50** copayment for all other drugs

Additional benefits

Medicare-covered foot care (podiatry)	**$10** copay
Medicare-covered chiropractic services	**$0** 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** or **10%** of the cost
Rehabilitation services	• Physical, occupational and speech therapy: **$10** copay • Cardiac rehabilitation: **$10** copay • Pulmonary rehabilitation: **$10** copay

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

Well Dine Meal Program

neal program for members following an inpatient stay in the hospital or nursing facility

Nurse Hotline

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

Over-the-Counter (OTC) mail order

Up to **$45** allowance every 3 months for the purchase of OTC supplies

Rewards for completing certain preventive health screenings and health and wellness activities.

SilverSneakers® fitness program

Basic fitness center membership including fitness classes.