Monthly Premium, Deductible and Limits

PLAN COSTS	
Monthly plan premium You must keep paying your Medicare Part B premium.	**$106** Depending on your level of Medicaid eligibility, your plan premium may be reduced.

PLAN COSTS	IN-NETWORK	OUT-OF-NETWORK
Medical deductible	This plan does not have a deductible.	
Pharmacy (Part D) deductible	**$250** for Tier 4, Tier 5	
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for medical services for the year.	**$3,200** in-network **$4,500** combined in- and out-of-network	**$4,500** combined in- and out-of-network

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
	$100 copayment per stay Your plan covers an unlimited number of days for an inpatient stay.	**20%** of the cost
OUTPATIENT HOSPITAL COVERAGE		
Outpatient surgery at outpatient hospital	**$100** copay	**20%** of the cost
Outpatient surgery at ambulatory surgical center	**$50** copay	**20%** of the cost
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**20%** of the cost
Specialists	**$25** copay	**20%** of the cost

You do not need a referral to receive covered services from plan 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.)

	IN-NETWORK	OUT-OF-NETWORK
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	**$0** copay or **20%** of the cost, depending on the service and where service is provided Any additional preventive services approved by Medicare during the contract year will be covered.

You do not need a referral to receive covered services from plan 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.)

	IN-NETWORK	OUT-OF-NETWORK
	Any additional preventive services approved by Medicare during the contract year will be covered.	
EMERGENCY CARE		
Emergency room 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.	**$120** copay	**$120** copay
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$25** copay at an urgent care center	**20%** of the cost at an urgent care center
OUTPATIENT CARE AND DIAGNOSTIC SERVICES, LABS AND IMAGING Cost share may vary depending on the service and where service is provided		
Diagnostic mammography	**$25** to **$80** copay	**20%** of the cost
Diagnostic radiology	**$50** to **$100** copay	**20%** of the cost
Lab services	**$0** to **$25** copay	**20%** of the cost
Diagnostic tests and procedures	**$0** to **$85** copay	**20%** of the cost
Outpatient X-rays	**$0** to **$85** copay	**20%** of the cost
Radiation therapy	**20%** of the cost	**20%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**$25** copay	**20%** of the cost

You do not need a referral to receive covered services from plan 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.)

	IN-NETWORK	OUT-OF-NETWORK
Routine hearing	**HER941** • **$0** copayment for fitting, routine hearing exams up to 1 per year. • **$0** copayment for adjustments up to 2 per year. • **$699** copayment for Advanced level hearing aid up to 1 per ear per year. • **$999** copayment for Premium level hearing aid up to 1 per ear per year. • Note: Includes 48 batteries per aid and 3 year warranty. • Fitting and adjustments are covered for 1 year after TruHearing hearing aid purchase. TruHearing provider must be used.	**HER941** • **$0** copayment for fitting, routine hearing exams up to 1 per year. • **$0** copayment for adjustments up to 2 per year. • **$699** copayment for Advanced level hearing aid up to 1 per ear per year. • **$999** copayment for Premium level hearing aid up to 1 per ear per year. • Note: Includes 48 batteries per aid and 3 year warranty. • Fitting and adjustments are covered for 1 year after TruHearing hearing aid purchase. • TruHearing provider must be used for in and out-of-network hearing aid benefit. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
DENTAL SERVICES The cost-share indicated below is what you pay for the covered service.		
Medicare-covered dental	**$25** copay	**20%** of the cost
Routine dental Dental benefits may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb** 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	**DEN916** • **0%** coinsurance for comprehensive oral evaluation or 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, prophylaxis (cleaning) up to 2 per year.	**DEN916** • **50%** coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **50%** coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years. • **50%** coinsurance for bitewing x-rays up to 1 set(s) per year. • **50%** coinsurance for intraoral x-rays up to 1 per year. • **50%** coinsurance for periodic oral exam, prophylaxis (cleaning) up to 2 per year.

You do not need a referral to receive covered services from plan 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.)

	IN-NETWORK	OUT-OF-NETWORK
Type select All Dental Networks > enter zip code > from the network drop down select HumanaDental Medicare.	• **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. • **70%** coinsurance for complete dentures, partial dentures up to 1 set(s) every 5 years. • **70%** coinsurance for adjustments to dentures, crown, denture reline up to 1 per year. • **$2000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits.	• **50%** coinsurance for necessary anesthesia with covered service up to unlimited per year. • **55%** coinsurance for amalgam and/or composite filling, simple or surgical extraction up to 2 per year. • **75%** coinsurance for complete dentures, partial dentures up to 1 set(s) every 5 years. • **75%** coinsurance for adjustments to dentures, crown, denture reline up to 1 per year. • **$2000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
VISION SERVICES		
Medicare-covered vision services	**$25** copay	**20%** of the cost
Medicare-covered diabetic eye exam	**$0** copay	**20%** of the cost
Medicare-covered glaucoma screening	**$0** copay	**20%** of the cost
Medicare-covered eyewear (post-cataract)	**$0** copay	**20%** of the cost

You do not need a referral to receive covered services from plan 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.)

	IN-NETWORK	OUT-OF-NETWORK
Routine vision The provider locator for routine vision can be found at **Humana.com** > Find a Doctor > from the Search Type drop down select Vision > Vision coverage through Medicare Advantage plans.	**VIS751** • **$0** copayment for refraction, routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for refraction, routine exam. • **$100** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglasses include ultraviolet protection and scratch resistant coating.	**VIS751** • **$0** copayment for refraction, routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for refraction, routine exam. • **$100** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglasses include ultraviolet protection and scratch resistant coating. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$100** copayment per stay	**20%** of the cost
Outpatient group and individual therapy visits Cost share may vary depending on where service is provided.	**$40** to **$85** copay	**20%** of the cost
SKILLED NURSING FACILITY (SNF)		
Your plan covers up to 100 days in a SNF	**$20** copay per day for days 1-20 **$184** copay per day for days 21-100	**20%** of the cost for days 1-100
PHYSICAL THERAPY		
	$40 copay	**20%** of the cost
AMBULANCE		
Ambulance (ground)	**$290** copay per date of service	**$290** copay per date of service
Ambulance (air)	**20%** of the cost	**20%** of the cost

You do not need a referral to receive covered services from plan 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.)

	IN-NETWORK	OUT-OF-NETWORK
TRANSPORTATION		
	Not covered	Not covered

Prescription Drug Benefits

MEDICARE PART B DRUGS		
Chemotherapy drugs	**20%** of the cost	**20%** of the cost
Other Part B drugs	**20%** of the cost	**20%** of the cost

PRESCRIPTION DRUGS

If you don't receive Extra Help for your drugs, you'll pay the following:

Deductible This plan has a **$250** deductible for Tier 4, Tier 5 drugs. You pay the full cost of these drugs until you reach $250. Then, you only pay your cost-share.

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach **$4,130**. 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.

Preferred cost-sharing

Pharmacy options	**Retail** To find the preferred cost-share retail pharmacies near you, go to **Humana.com/pharmacyfinder**		**Mail order** Humana Pharmacy®	
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 1: Preferred Generic	$0	$0	$0	$0
Tier 2: Generic	$6	$18	$6	$0
Tier 3: Preferred Brand	$47	$141	$47	$131
Tier 4: Non-Preferred Drug	$100	$300	$100	$290
Tier 5: Specialty Tier	28%	N/A	28%	N/A

You do not need a referral to receive covered services from plan 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.

Standard cost-sharing				
Pharmacy options	**Retail** All other network retail pharmacies.		**Mail order** Walmart Mail, PillPack	
	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	28%	N/A	28%	N/A

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

Specialty drugs are limited to a 30 day supply.

If you receive Extra Help for your drugs, you'll pay the following:

Deductible You may pay **$0** or **$92** depending on your level of Extra Help (for Tier 4, Tier 5). If your deductible is **$92**, you pay the full cost of these drugs until you reach **$92**. Then, you only pay your cost-share.

Pharmacy cost-sharing		
For generic drugs (including brand drugs treated as generic), either:	**30-day supply**	**90-day supply**
	$0 copay; or **$1.30** copay; or **$3.70** copay ; or **15%** of the cost	**$0** copay; or **$1.30** copay; or **$3.70** copay ; or **15%** of the cost
For all other drugs, either:	**$0** copay; or **$4** copay; or **$9.20** copay ; or **15%** of the cost	**$0** copay; or **$4** copay; or **$9.20** copay ; or **15%** of the cost

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 **25 percent** of the plan's cost for covered generic drugs until your costs total **$6,550** — 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 **$6,550**, you pay the greater of:
- **5%** of the cost, or
- **$3.70** copay for generic (including brand drugs treated as generic) and a **$9.20** copayment for all other drugs

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
Medicare-covered foot care (podiatry)	**$25** copay	**20%** of the cost
Medicare-covered chiropractic services	**$20** copay	**20%** of the cost
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**20%** of the cost	**20%** of the cost
Medical Supplies	**20%** of the cost	**20%** of the cost
Prosthetics (artificial limbs or braces)	**20%** of the cost	**20%** of the cost
Diabetic monitoring supplies Cost share may vary depending on where service is provided.	**$0** copay or **10%** to **20%** of the cost	**20%** of the cost
REHABILITATION SERVICES		
Physical, occupational and speech therapy	**$40** copay	**20%** of the cost
Cardiac rehabilitation	**$30** copay	**20%** of the cost
Pulmonary rehabilitation	**$30** copay	**20%** of the cost
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered

H5216063000

Specialist	**$25** copay	Not Covered
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered

H5216063000