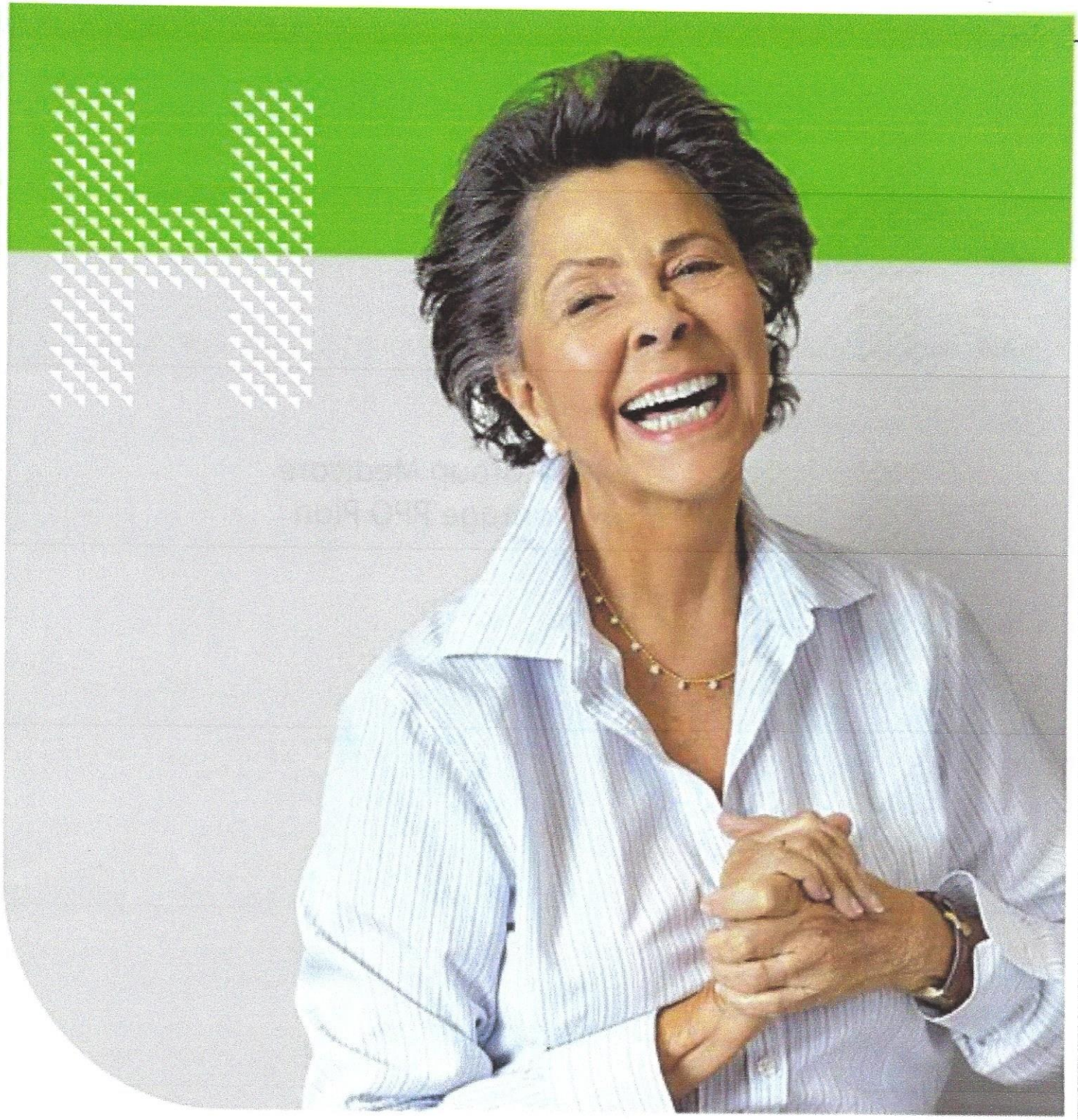
Humana

HUMANA GROUP MEDICARE PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

PPO



Group Medicare PPO

Indiana Firefighters Association

Humana.

The Rep for Indiana Firefighters
Humana Insurance PPO Plan is

Jody Hagewood

You can reach her at 502-424-5051

Let's talk about the **Humana Group Medicare Advantage PPO** Plan.

Find out more about the Humana Group Medicare Advantage PPO plan – including the services it covers – in this easy-to-use guide.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, refer to the "Evidence of Coverage".

To be eligible

To join the Humana Group Medicare Advantage PPO plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Plan name:

Humana Group Medicare Advantage PPO plan

How to reach us:

Members should call toll-free **1-866-396-8810** for questions **(TTY/TDD 711)**

Call Monday – Friday, 8 a.m. - 9 p.m. Eastern Time.

Or visit our website: **Humana.com**

Humana Group Medicare Advantage PPO plan has a network of doctors, hospitals, and other providers. For more information, please call Group Medicare Customer Care.

A healthy partnership

Get more from your plan — with extra services and resources provided by Humana!

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 Humana, your employer/union group, or your employer group benefits plan administrator.	
Medical deductible	**$1,000** per year for some combined in- and out-of-network services	**$1,000** 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** **$6,700** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy, COVID-19 Care Package ; COVID-19 Testing ; COVID-19 Treatment ; Dental Services (Routine) ; Fitness Program ; Health Education Services ; Hearing Services (Routine) ; Meal Benefit ; OTC Drugs and Supplies ; Smoking Cessation (Additional) ; Vision Services (Routine) and the Plan Premium. 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** **$10,000** out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy, COVID-19 Care Package ; COVID-19 Testing ; COVID-19 Treatment ; Dental Services (Routine) ; Fitness Program ; Health Education Services ; Hearing Services (Routine) ; Meal Benefit ; OTC Drugs and Supplies ; Smoking Cessation (Additional) ; Vision Services (Routine) and the Plan Premium do not apply to the combined maximum out-of-pocket. Out-of-Network Exclusions: Part D Pharmacy, COVID-19 Testing ; COVID-19 Treatment ; Dental Services (Routine) ; Hearing Services (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

Note: *some services require prior authorization.*

Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
		the full cost for the rest of the year on covered hospital and medical services.

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
Our 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.	**$225** copay per day for days 1-7	**30%** of the cost per stay
OUTPATIENT HOSPITAL COVERAGE		
Outpatient hospital visits	**$20** to **$225** copay or **20%** of the cost	**20%** to **30%** of the cost
Ambulatory surgical center	**$175** copay	**30%** of the cost
Wound care visits	**$45** copay	**30%** of the cost
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$5** copay	**30%** of the cost
Specialists	**$45** copay	**30%** 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.**	**$0** copay or **30%** of the cost for Medicare-covered preventive services **30%** of the cost for a supplemental annual physical exam

Note: *some services require prior authorization.*

Covered Medical and Hospital 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.	**$90** copay for Medicare-covered emergency room visit(s)	**$90** copay 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.	**$5** to **$45** copay	**30%** of the cost
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic radiology	**$150** to **$195** copay	**30%** of the cost
Lab services	**$0** to **$40** copay	**30%** of the cost
Diagnostic tests and procedures	**$0** to **$75** copay	**30%** of the cost
Outpatient X-rays	**$5** to **$75** copay	**30%** of the cost
Radiation therapy	**$45** to **$50** copay	**30%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**$45** copay	**30%** of the cost
Routine hearing	• $0 copay for routine hearing exams up to 1 per year.	• $0 copay for routine hearing exams up to 1 per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Note: *some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
DENTAL SERVICES		
Medicare-covered dental	**$45** copay	**30%** of the cost
Routine dental	• $0 copay for bitewing x-rays up to 1 set(s) per year. • $0 copay for amalgam filling, oral evaluation, prophylaxis (cleaning) up to 1 per year.	• $0 copay for bitewing x-rays up to 1 set(s) per year. • $0 copay for amalgam filling, oral evaluation, prophylaxis (cleaning) up to 1 per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
VISION SERVICES		
Medicare-covered vision services	**$45** copay	**30%** of the cost
Medicare-covered diabetic eye exam	**$0** copay	**30%** of the cost
Medicare-covered glaucoma screening	**$0** copay	**30%** of the cost
Medicare-covered eyewear (post-cataract)	**$0** copay	**$0** copay
Routine vision	• $40 combined maximum benefit coverage amount per year for routine exam, which includes refraction, up to 1 per year. • $100 combined maximum benefit coverage amount per year for contact lenses, eyeglasses-lenses and frames.	• $40 combined maximum benefit coverage amount per year for routine exam, which includes refraction, up to 1 per year. • $100 combined maximum benefit coverage amount per year for contact lenses, eyeglasses-lenses and frames. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Note: *some services require prior authorization.*