2025

Summary of Benefits

Humana Group Medicare Advantage PPO Plan
PPO 079/266

Michigan Catholic Conference

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 your employer/union group.	
Medical deductible	**$100** per year for some combined in- and out-of-network services	**$100** 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** **$1,000** 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; Personal Emergency Response System; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); 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** **$1,000** out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy; Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Personal Emergency Response System; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; 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; Hearing Services (Routine); Personal Emergency Response System; 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.*

Note: *some services require prior authorization and referrals from providers.*

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.	**$0** per admit	**$0** per admit
OUTPATIENT HOSPITAL COVERAGE		
Outpatient hospital visits	**$0** to **$25** copay	**$0** to **$25** copay
Observation services	**$0** copay	**$0** copay
Ambulatory surgical center	**$0** copay	**$0** copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$15** copay	**$15** copay
Specialists	**$15** copay	**$15** copay
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.	**$65** copay for Medicare-covered emergency room visit(s)	**$65** 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.	**$15** to **$40** copay	**$15** to **$40** copay
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic radiology	**$15** copay	**$15** copay
Lab services	**$0** copay	**$0** copay

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
Diagnostic tests and procedures	**$0** to **$40** copay	**$0** to **$40** copay
Outpatient x-rays	**$15** to **$40** copay	**$15** to **$40** copay
Radiation therapy	**$15** copay	**$15** copay
HEARING SERVICES		
Medicare-covered hearing: diagnostic hearing and balance exams	**$15** copay	**$15** copay
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. **$3,000** maximum benefit coverage amount for hearing aid(s) (all types) up to 2 every 3 years. Note: Includes 80 batteries per aid and 3 year warranty.	
DENTAL SERVICES		
Medicare-covered dental	**$15** copay (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)	**$15** copay (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	**$15** copay (services include diagnosis and treatment of diseases and injuries of the eye)	**$15** copay (services include diagnosis and treatment of diseases and injuries of the eye)
Medicare-covered diabetic eye exam (1 per year)	**$0** copay	**$0** copay
Medicare-covered glaucoma screening (1 per year)	**$0** copay	**$0** copay
Medicare-covered eyewear (post-cataract)	**$15** copay	**$15** copay

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
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.
PERSONAL EMERGENCY RESPONSE SYSTEM		
Personal Emergency Response System (PERS)	**$0** copay for either an On The Go Mobile personal help button or an On the Go Mobility personal help button. Both function in and out of the home. On The Go uses two way voice communication & five location seeking technologies to send help quickly to wherever the member is located. On the Go Mobility mobile device offers fall detection remotely activated/deactivated, up to 5 days of battery life, location services, and wandering. Accommodation for Pacemakers and Implanted Devices when worn at the waist with free leather pouch and auto fall detection deactivated.	
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. Unlimited.	**$0** per admit	**$0** per admit
Outpatient group and individual therapy visits	**Outpatient therapy visit:** **$15** to **$40** copay **Partial Hospitalization:** **$0** copay	**Outpatient therapy visit:** **$15** to **$40** copay **Partial Hospitalization:** **$0** copay

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
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 1-100	**$0** copay per day for days 1-100
PHYSICAL THERAPY		
	$15 to **$25** copay	**$15** to **$25** copay
AMBULANCE		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	**$100** copay	**$100** copay
TRANSPORTATION		
	$0 copay for plan approved location up to 24 one-way trip(s) per year. This benefit is not to exceed 60 miles per trip.	**$0** copay for plan approved location up to 24 one-way trip(s) per year. This benefit is not to exceed 60 miles per trip. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
PART B PRESCRIPTION DRUGS		
Medicare Part B covered drugs	**$0** copay or **0%** of the cost	**$0** copay or **0%** of the cost
Medicare Part B insulin drugs	**$0** copay or **0%** of the cost	**$0** copay or **0%** 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.	**$15** copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year.	**$15** copay 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	**$15** copay	**$15** copay
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	**$15** copay	**$15** copay

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
DIABETES MANAGEMENT TRAINING		
	$0 copay	**$0** copay
FOOT CARE (PODIATRY)		
Medicare-covered foot care	**$0** copay	**$0** copay
HOME HEALTH CARE		
	$0 copay	**$0** copay
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**0%** to **15%** of the cost	**0%** to **15%** of the cost
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)	**15%** of the cost	**15%** of the cost
Diabetes monitoring supplies	**$0** copay or **0%** of the cost	**$0** copay or **0%** of the cost
Continuous glucose monitors	**0%** to **15%** of the cost	**0%** to **15%** of the cost
OUTPATIENT SUBSTANCE ABUSE		
Outpatient group and individual substance abuse treatment visits	**Outpatient therapy visit:** **$15** to **$40** copay **Partial Hospitalization:** **$0** copay	**Outpatient therapy visit**: **$15** to **$40** copay **Partial Hospitalization:** **$0** copay
REHABILITATION SERVICES		
Occupational and speech therapy	**$15** to **$25** copay	**$15** to **$25** copay
Cardiac rehabilitation	**$15** copay	**$15** copay
Pulmonary rehabilitation	**$15** copay	**$15** copay
RENAL DIALYSIS		
Renal dialysis	**$10** copay	**$10** copay
Kidney disease education services	**$0** copay	**$0** copay
HUMANA IN-NETWORK TELEHEALTH VENDORS, i.e. MDLive (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered
Specialist	**$15** copay	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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