

County of Orange Benefit Highlights

Please visit your custom Humana site at your.humana.com/countyoforange for plan information, documents and more—or call Humana Group Medicare Customer Care at **866-771-1615 (TTY: 711)**, Monday – Friday, 5 a.m. – 9 p.m., Pacific time.

This is not a complete description of benefits. A complete list of covered services will be available in your “Evidence of Coverage.” All services covered by Original Medicare are also covered by this plan.

Humana Group Medicare PPO Plan	In-network	Out-of-network
Annual deductible		n/a
Annual medical maximum out-of-pocket (does not include Part D/Rx)		\$3,400
Hospital care		
Outpatient hospital visits		\$0 to \$40
Inpatient hospital		\$100 per day, days 1-5
Physician and facility services		
Primary care provider		\$25 copay
Specialist		\$40 copay
Preventive care		\$0 copay
Outpatient ambulatory surgical center		\$25 copay
Durable medical equipment		0-10% of the cost
Emergency services		
Emergency room care		\$65 copay
Urgently needed care at urgent care center		\$40 copay
Hearing services		
Medicare-covered hearing		\$40 copay
Dental services		
Medicare-covered dental		\$40 copay
Vision services		
Medicare-covered vision		\$40 copay
Chiropractic		
Medicare-covered chiropractic visit(s)		\$20 copay
Acupuncture		
Medicare-covered acupuncture		\$15 copay
<ul style="list-style-type: none"> - 20 combined in- and out-of-network visit limit per plan year - Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements. Please refer to your “Evidence of Coverage” for the details on Medicare covered acupuncture services. 		
Podiatry		
Medicare-covered foot care		\$25 copay

This information is not a complete description of benefits. 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" or call the number on the back of your member ID card for more information. All services covered by Original Medicare are also covered by this plan.

Prescription Drug Coverage	30-day Standard Retail or Mail	90-day Standard Retail or Mail
Tier 1 Generic or preferred generic	\$0	\$0
Tier 2 Preferred brand	\$40	\$80
Tier 3 Nonpreferred brand	\$45	\$100
Tier 4 Specialty	\$45	N/A

Pharmacy (Part D) deductible

This plan does not have a deductible.

Prescription Drug Tiers

There may be generic and brand-name drugs, as well as Medicare-covered drugs, in each of the tiers. To identify commonly prescribed drugs in each tier, see the Prescription Drug Guide/Formulary. To view the most complete and current Drug Guide information online, visit www.Humana.com/SearchResources, locate Prescription Drug section, select www.Humana.com/MedicareDrugList link; under Printable drug lists, click Printable Drug lists, select future plan year, select Group Medicare under Plan Type and search for **GRP62**.

Important Message About What You Pay for Vaccines

Member cost share of all Part D vaccines listed on the Advisory Committee on Immunization Practices (ACIP) list **will be \$0**. For more information regarding the Centers for Disease Control and Prevention's ACIP vaccine recommendations, please go to www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html. Or call the Customer Care number on the back of your member ID.

Important Message About What You Pay for Insulin

Member cost share of this plan's covered insulin products covered under Part Band Part D will be **no more than \$35 for every one-month** (up to a 30-day) supply, no matter what cost-sharing tier it's in.

Mail order option

In addition to in-network retail pharmacies you also have the option to utilize mail order.



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