

MEDICAL BENEFITS ... AT A GLANCE

HUMANA MEDICARE ADVANTAGE	
In-Network ¹ (must have Medicare A & B)	
Health Reimbursement Account (Metro funded) ²	N/A
Your Share of the Deductible	\$0
Coinsurance Maximum	N/A
Annual Out-of-Pocket Maximum (deductible & coinsurance)	\$1,000/individual
Medical Services	
After deductible, plan pays... (unless otherwise noted)	
Well Care/Preventive Care	
- Age 7 and older	100% (including pap smears, mammograms, pelvic exams, prostate exams, bone mass measurement)
- Under age 7	N/A
Office Visits (telehealth may be available; see page 10)	
- Primary Care Physician ³	100% after \$10 copay
- Specialist	100% after \$10 copay
In-office Procedures (surgery, consultation, allergy injections)	100% after \$10 copay
Maternity	
- Prenatal Care	Covered as any other inpatient service
- Delivery	100%
Hospital	100% (unlimited days)
Emergency Room	100% after \$50 copay; worldwide coverage (copay waived if admitted within 72 hours)
Mental Health/Substance Abuse	
- Outpatient	100% after \$10 copay
- Inpatient (pre-authorization required)	100% (190-day lifetime maximum in psychiatric hospital)
Routine Hearing Exam	100% after \$10 copay
Hearing Aid Benefit	\$200 allowance every 2 years
Routine Vision Exam	100% after \$10 copay
Diabetic Vision Exam	100%
Eyewear	\$100 allowance per year
Dental care	\$100 allowance per year
Prescription Drugs	
You pay...	
1-month supply	
- Generic	\$10 copay
- Brand	\$20 copay
3-month supply (maintenance drugs)	2x above copays at Humana mail order pharmacy or 3x above copays at other participating retail pharmacies; see page 5

¹ Out-of-network care is covered at the same level as in-network care as long as provider accepts Medicare and agrees to bill Humana.
² Pensioners with Medicare A & B are not eligible to receive the Health Reimbursement Account (HRA) Fund and are immediately responsible for your share of the deductible.
³ Primary Care Physicians include pediatricians, family and general practitioners, internists and OB/GYNs. Specialists include physicians highly trained in specific areas such as cardiology, dermatology, neurology, podiatry, oncology and specialized OB/GYNs.

BCBS PPO		CIGNA CHOICE FUND	
In-Network (Blue Network P)	Out-of-Network ⁴	In-Network (Open Access Plus)	Out-of-Network ⁴
N/A	N/A	\$1,100/single; \$2,200/family ²	
\$0	\$200/single; \$600/family	\$450/single; \$900/family	
\$1,000/single \$2,000/family	\$5,000/single \$10,000/family	\$700/single \$1,400/family	\$4,550/single \$9,100/family
\$1,000/single \$2,000/family	\$5,000/single \$10,000/family	\$1,150/single \$2,300/family	\$5,000/single \$10,000/family
Medical Services			
After deductible, plan pays... (unless otherwise noted)			
Well Care/Preventive Care			
100% up to \$750, then 80% ⁵	60% ⁵	100%	70%
80%	60%	100%	70%
80% after \$20 copay	60% after \$20 copay	90%	70%
80% after \$30 copay	60% after \$30 copay	90%	70%
80% after office visit copay	60% after office visit copay	90%	70%
You pay \$20 copay for initial visit 80%	You pay \$20 copay for initial visit 60%	90%	70%
80%	60%	90%	70%
80% after \$100 copay (copay waived if admitted)	60% after \$100 copay (copay waived if admitted)	90%	90%
80% after \$20 copay	60% after \$20 copay	90%	70%
80%	60%	90%	70%
Covered if performed during preventive care physical exam			
Not covered			
Covered if performed during preventive care physical exam			
80%	60%	90%	70%
80% after cataract surgery	60% after cataract surgery	90% after cataract surgery	70% after cataract surgery
Not covered			
		After deductible:	
\$10 copay		10% of discounted cost	
\$30 copay		30% of discounted cost	
2 times above copays through certain retail pharmacies and mail order; see page 5		Same as above through certain retail pharmacies and mail order; see page 5	

⁴ If you use an out-of-network provider and charges exceed the Maximum Allowable Charge (MAC), you will be responsible for the difference. In-network providers have agreed not to exceed MAC.
⁵ Screening colonoscopies, mammograms, PSA tests and PAP exams are covered at 80% after office visit copay (in-network) and 60% after office visit copay (out-of-network), but are not included in the \$750 well-care benefit limit.