2025

Summary of Benefits

HumanaChoice H5525-083 (PPO)

North Carolina

Our service area includes the following county/counties in North Carolina: Alamance, Alexander, Alleghany, Anson, Ashe, Avery, Beaufort, Bertie, Bladen, Brunswick, Buncombe, Burke, Cabarrus, Caldwell, Camden, Caswell, Catawba, Chatham, Cherokee, Clay, Cleveland, Columbus, Cumberland, Currituck, Davidson, Davie, Duplin, Durham, Edgecombe, Forsyth, Franklin, Gaston, Gates, Graham, Granville, Greene, Guilford, Halifax, Harnett, Haywood, Henderson, Hertford, Hoke, Hyde, Iredell, Jackson, Johnston, Jones, Lee, Lenoir, Lincoln, Macon, Madison, Martin, McDowell, Mecklenburg, Mitchell, Montgomery, Moore, Nash, New Hanover, Northampton, Orange, Pamlico, Pasquotank, Pender, Perquimans, Person, Polk, Randolph, Richmond, Robeson, Rockingham, Rowan, Rutherford, Sampson, Scotland, Stanly, Stokes, Surry, Swain, Transylvania, Tyrrell, Union, Vance, Wake, Warren, Washington, Watauga, Wayne, Wilkes, Wilson, Yadkin, Yancey.

Monthly Premium, Deductible and Limits

PLAN COSTS	
Monthly plan premium	**$0** You must keep paying your Medicare Part B premium.
Part B premium reduction	Your plan will reduce your Monthly Part B premium by up to **$4** but by no more than Original Medicare's Part B Premium for 2025.
Medical deductible	**$400** combined The following services listed are excluded from the combined in-network and out-of-network deductible: In-Network only: • Ambulance Services • Chemotherapy Drugs and Administration • Diabetic Monitoring Supplies • Diagnostic Colonoscopy • Diagnostic Mammography • Lab Services • Medicare Part B Insulin Drugs • Other Medicare Part B Drugs • Primary Care Physician's Office • Specialist's Office Both In-Network and Out-of-Network: • Emergency Room Services • Medicare Covered Preventive Services (including Immunizations (Flu & Pneumonia)) • Services not covered by Original Medicare • Urgently Needed Services at Urgent Care Centers
Pharmacy (Part D) deductible	**$0** deductible for Tier 1 and Tier 2 **$450** deductible for Tier 3, Tier 4 and Tier 5
Maximum out-of-pocket responsibility	**$9,350** in-network **$14,000** combined in- and out-of-network The most you pay for copays, coinsurance and other costs for covered medical services for the year.

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

Humana.

Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
INPATIENT HOSPITAL COVERAGE		
This plan covers an unlimited number of days for an inpatient stay.	**$399** copay per day for days 1-6 **$0** copay per day for days 7-90	**50%** of the cost
OUTPATIENT HOSPITAL COVERAGE		
Diagnostic colonoscopy	**$0** copay	**$0** copay
Diagnostic mammography	**$0** copay	**50%** of the cost
Surgery services	**$450** copay	**50%** of the cost
AMBULATORY SURGERY CENTER		
Diagnostic colonoscopy	**$0** copay	**$0** copay
Surgery services	**$400** copay	**50%** of the cost
DOCTOR VISITS		
Primary care provider (PCP)		
• PCP's office	**$0** copay	**50%** of the cost
• Telehealth	**$0** copay	**Not Covered**
Specialist		
• Specialist's office	**$50** copay	**50%** of the cost
• Telehealth	**$50** copay	**Not Covered**
PREVENTIVE CARE		
This plan covers all Medicare preventive services including: • **Abdominal aortic aneurysm screening** • **Alcohol misuse screening & counseling** • **Annual Wellness Visit (AWV)** • **Bone mass measurement** • **Breast cancer screening (mammogram)** • **Cardiovascular disease risk reduction visit** • **Cardiovascular disease screenings** • **Cervical and vaginal cancer screening** • **Colorectal cancer screening** • **Depression screening**	**$0** copay	**$0** copay or **50%** of the cost, depending on the service and where service is provided

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
• **Diabetes screenings** • **Diabetes self-management training** • **Glaucoma screening** • **HIV screening** • **Immunizations** • **Lung cancer Screening** • **Medical nutrition therapy** • **Medicare Diabetes Prevention Program (MDPP)** • **Obesity screening and therapy** • **Prostate cancer screening** • **Routine physical exam** • **Sexually transmitted infections (STIs) screening and counseling** • **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)** • **"Welcome to Medicare" preventive visit** Any additional preventive services approved by Medicare during the contract year will be covered.		
EMERGENCY CARE		
Emergency services at emergency room If you are admitted to the same hospital within 24 hours, you do not have to pay your share of the cost for the emergency care. When placed in observation, member pays observation cost-share instead of emergency room cost-share.	**$110** copay	**$110** copay
Physician and professional services at emergency room	**$0** copay	**$0** copay

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

Humana.

Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
URGENTLY NEEDED SERVICES		
• **Telehealth**	**$45** copay	**Not Covered**
• **Urgent care center**	**$45** copay	**$45** copay
Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical attention.		
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Advanced imaging services (MRI, MRA, PET and CT scan)		
• Freestanding radiological facility	**$200** copay	**50%** of the cost
• Outpatient hospital	**$325** copay	**50%** of the cost
• PCP's office	**$200** copay	**50%** of the cost
• Specialist's office	**$200** copay	**50%** of the cost
Basic radiological services (X-rays)		
• Freestanding radiological facility	**$50** copay	**50%** of the cost
• Outpatient hospital	**$125** copay	**50%** of the cost
• PCP's office	**$0** copay	**50%** of the cost
• Specialist's office	**$50** copay	**50%** of the cost
• Urgent care center	**$45** copay	**50%** of the cost
Diagnostic mammography		
• Freestanding radiological facility	**$0** copay	**50%** of the cost
• Specialist's office	**$0** copay	**50%** of the cost
Diagnostic procedures and tests		
• Outpatient hospital	**$120** copay	**50%** of the cost
• PCP's office	**$0** copay	**50%** of the cost
• Specialist's office	**$50** copay	**50%** of the cost
• Urgent care center	**$45** copay	**50%** 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 this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Lab services		
• Freestanding laboratory	**$0** copay	**50%** of the cost
• Outpatient hospital	**$50** copay	**50%** of the cost
• PCP's office	**$0** copay	**50%** of the cost
• Specialist's office	**$0** copay	**50%** of the cost
• Urgent care center	**$45** copay	**50%** of the cost
Nuclear medicine and services		
• Freestanding radiological facility	**$325** copay	**50%** of the cost
• Outpatient hospital	**$325** copay	**50%** of the cost
Sleep study		
• Member's home	**$0** copay	**$0** copay
• Outpatient hospital	**$120** copay	**50%** of the cost
• Specialist's office	**$50** copay	**50%** of the cost
Therapeutic radiology (Radiation therapy)		
• Freestanding radiological facility	**20%** of the cost	**50%** of the cost
• Outpatient hospital	**20%** of the cost	**50%** of the cost
• Specialist's office	**$50** copay	**50%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**$50** copay	**50%** 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 this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

Humana.

Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Mandatory supplemental hearing benefit	**HER939** • **$0** copay for routine hearing exams up to 1 per year. • **$499** copay for each Advanced level hearing aid up to 1 per ear per year. • **$799** copay for each Premium level hearing aid up to 1 per ear per year. Hearing aid purchase includes: • Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models • Rechargeable style options available for Premium and Advanced aids for an additional **$50** per aid **You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (TTY: 711).**	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
DENTAL SERVICES		
Medicare-covered dental	**$50** copay	**50%** of the cost
Mandatory supplemental dental benefit Limitations and exclusions may apply. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. Dental benefits under this plan may not cover all ADA procedure codes. Any services received that are not listed will not be covered by the plan and will be the member's	**DENE58** • Plan covers up to **$1250** allowance every year for non-Medicare covered preventive and comprehensive dental services. • You are responsible for any amount above the dental coverage limit. • Any amount unused at the end of the year will expire.	**DENE58** • Plan covers up to **$1250** allowance every year for non-Medicare covered preventive and comprehensive dental services. • You are responsible for any amount above the dental coverage limit. • Any amount unused at the end of the year will expire.

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

	IN-NETWORK	OUT-OF-NETWORK
responsibility. The member is responsible for any amount above the dental coverage limit. Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. Information regarding each plan is available at **Humana.com/sb**. In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule (but any applicable coinsurance payment still applies). Out-of-network dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Members may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Please see below for provider locator instructions. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement. The coinsurance level will apply to the usual and customary fees in your area. See	• Your benefit can be used for most dental treatments such as: • Preventive dental services, such as exams, routine cleanings, etc. • Basic dental services, such as fillings, extractions, etc. • Major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges etc. • Frequency limits may apply. • Note: The allowance cannot be used on fluoride, cosmetic services and implants.	• Your benefit can be used for most dental treatments such as: • Preventive dental services, such as exams, routine cleanings, etc. • Basic dental services, such as fillings, extractions, etc. • Major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges etc. • Frequency limits may apply. • Note: The allowance cannot be used on fluoride, cosmetic services and implants. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

Humana.

Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Chapter 2 Payment Requests Contact Information in your Evidence of Coverage or visit **Humana.com** for information on requesting reimbursement. When visiting an out-of-network provider there could be a difference between Humana's reimbursement and the dentist's charges. Members are responsible for this difference when visiting an out-of-network provider; this is known as balanced billing. Find a dentist in the nationwide Humana Dental Medicare network at **Humana.com** > Find Care.		
VISION SERVICES		
Eyewear (post cataract surgery)	**$0** copay	**$0** copay
Medicare-covered diabetic eye exam	**$0** copay	**50%** of the cost
Medicare-covered vision services The provider locator for Medicare-covered vision can be found at **Humana.com** > Find Care.	**$50** copay	**50%** 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 this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Mandatory supplemental vision benefit The mandatory supplemental vision benefits are provided through the Humana Medicare Insight Network. The provider locator can be found at **Humana.com** > Find Care.	**VIS692** • **$0** copay for routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for routine exam. • **$150** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • OR • **$200** maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year. • Maximum benefit coverage amounts cannot be combined. PLUS providers are part of the Humana Medicare Insight Network and are indicated in the provider locator search results.	**VIS692** • **$0** copay for routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for routine exam. • **$150** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. • Maximum benefit coverage amounts cannot be combined.
MENTAL HEALTH SERVICES		
Inpatient This plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$399** copay per day for days 1-5 **$0** copay per day for days 6-90	**50%** 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 this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

Humana.

Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Mental health therapy visits		
• Outpatient hospital	**$100** copay	**50%** of the cost
• Partial hospitalization	**$80** copay	**50%** of the cost
• Specialist's office	**$45** copay	**50%** of the cost
Outpatient substance abuse services		
• Outpatient hospital	**$100** copay	**50%** of the cost
• Partial hospitalization	**$80** copay	**50%** of the cost
• Specialist's office	**$45** copay	**50%** of the cost
• Telehealth	**$45** copay	**Not Covered**
SKILLED NURSING FACILITY (SNF)		
This plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$214** copay per day for days 21-100	**50%** of the cost for days 1-100
AMBULANCE		
	$315 copay per date of service	**$315** copay per date of service
TRANSPORTATION		
	Not Covered	

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit ***Humana.com/PAL****.*

Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
MEDICARE PART B DRUGS Some rebatable Part B drugs may be subject to a lower coinsurance.		
Allergy shots and serum		
• PCP's office	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
Chemotherapy drugs		
• Outpatient hospital	**20%** of the cost	**50%** of the cost
• Specialist's office	**20%** of the cost	**50%** of the cost
Other Part B drugs		
• Outpatient hospital	**20%** of the cost	**20%** of the cost
• PCP's office	**20%** of the cost	**20%** of the cost
• Pharmacy	**20%** of the cost	**20%** of the cost
• Specialist's office	**20%** of the cost	**20%** of the cost
Part B Insulin		
• Outpatient hospital	**20%** of the cost	**20%** of the cost
• PCP's office	**20%** of the cost	**20%** of the cost
• Pharmacy	**20%** of the cost	**20%** of the cost
• Specialist's office	**20%** of the cost	**20%** of the cost
You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan.		

Prescription Drug Benefits

PLAN HIGHLIGHTS	
$0 copays	**$0** copays at select pharmacy locations and tiers. Additional details below.
Deductible	**$0** deductible for Tier 1 and Tier 2
Insulin costs	You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan.
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

Humana.

DEDUCTIBLE

$0 deductible for Tier 1 and Tier 2. This plan has a **$450** deductible for Tier 3, Tier 4 and Tier 5 drugs. You pay the full cost of these drugs until you reach **$450**. Then, you only pay your cost-share.

INITIAL COVERAGE

You pay the following until your total yearly out-of-pocket drug costs reach **$2,000**. Once you reach this amount, you will enter the Catastrophic Stage.

Pharmacy Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		**Standard Mail-Order Cost-Sharing**		**Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy™	
Day supply	**30-day**	**90-day***	**30-day**	**90-day***	**30-day**	**90-day***
Tier 1: Preferred Generic	$0	$0	$10	$30	$0	$0
Tier 2: Generic	$0	$0	$20	$60	$0	$0
Tier 3: Preferred Brand	$47	$141	$47	$141	$47	$131
Tier 4: Non-Preferred Drug	43%	43%	43%	43%	43%	43%
Tier 5: Specialty Tier	27%	N/A	27%	N/A	27%	N/A

You have several options for filling your prescriptions, including retail and mail-order pharmacies. CenterWell Pharmacy® is the preferred mail-order, cost-sharing pharmacy for many Humana plans, which means you may pay as little as **$0** for certain Tier 1 and Tier 2 generics. Learn more at **CenterWellPharmacy.com**.

Other pharmacies are available in our network. To find which pharmacies are available in our network, go to **Humana.com/pharmacyfinder**.
*Some drugs are limited to a 30-day supply.

You won't pay more than **$35** for a one-month (up to 30-day) supply of each plan-covered insulin product regardless of cost-sharing tier, even if you haven't paid your deductible.

Insulin Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		**Standard Mail-Order Cost-Sharing**		**Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy™	
Day supply	**30-day**	**90-day***	**30-day**	**90-day***	**30-day**	**90-day***
Tier 3: Preferred Brand	$35	$105	$35	$105	$35	$95
Tier 5: Specialty Tier	$35	N/A	$35	N/A	$35	N/A

Other pharmacies are available in our network. To find which pharmacies are available in our network, go to **Humana.com/pharmacyfinder**.

*Some drugs are limited to a 30-day supply.

CATASTROPHIC COVERAGE

After your total out-of-pocket costs reach **$2,000** you pay **$0** for plan-covered Part D drugs.

EXTRA HELP

If you receive "Extra Help" for your drugs you will have a **$0** deductible.

Prior to reaching your annual **$2,000** out-of-pocket limit you will pay one of the following depending on your level of "Extra Help:"

- **$4.90** for generic/preferred multi-source drug or biosimilar; **$12.15** for any other drug; OR
- **$1.60** for generic/preferred multi-source drug or biosimilar; **$4.80** for any other drug; OR
- **$0** for all drugs

After reaching your annual **$2,000** out-of-pocket limit, you will pay **$0** for the remainder of the calendar year, regardless of the level of "Extra Help" you receive. Additional information will be available on your LIS rider.

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 (TTY: 1-800-325-0778), Monday – Friday, 7 a.m. – 7 p.m. For more information on your prescription drug benefit, please call us or access your Evidence of Coverage online.

If you reside at an in-network long-term care facility, you pay the same as you would at an in-network retail pharmacy. Under certain situations you may be able to get drugs from an out-of-network pharmacy but may pay more than you would pay at an in-network pharmacy.

Humana.

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
Acupuncture services (Medicare-covered)	**$50** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.	**$50** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Chiropractic services (Medicare-covered)	**$15** copay	**50%** of the cost
Podiatry services (Medicare-covered)	**$50** copay	**50%** of the cost
MEDICAL EQUIPMENT/SUPPLIES		
Continuous glucose monitor (CGM)		
• DME provider	**10%** of the cost	**10%** of the cost
• Pharmacy	**10%** of the cost	**10%** of the cost
Diabetic monitoring supplies		
• Diabetic supplier	**20%** of the cost	**50%** of the cost
• Network retail pharmacy	**10%** of the cost	**50%** of the cost
• Preferred diabetic supplier	**$0** copay	**Not Covered**
Durable medical equipment (DME)	**10%** of the cost	**10%** of the cost
Medical supplies at medical supplier	**20%** of the cost	**50%** of the cost
Prosthetics devices and related supplies at prosthetics provider	**20%** of the cost	**50%** of the cost
REHABILITATION SERVICES		
Cardiac rehabilitation services		
• Outpatient hospital	**$25** copay	**50%** of the cost
• Specialist's office	**$25** copay	**50%** of the cost
Occupational therapy		
• Comprehensive outpatient rehab facility	**$25** copay	**50%** of the cost
• Outpatient hospital	**$25** copay	**50%** of the cost
• Specialist's office	**$25** copay	**50%** of the cost

Additional Benefits (cont.)

Physical therapy		
• Comprehensive outpatient rehab facility	**$25** copay	**50%** of the cost
• Outpatient hospital	**$25** copay	**50%** of the cost
• Specialist's office	**$25** copay	**50%** of the cost
Pulmonary rehabilitation		
• Outpatient hospital	**$25** copay	**50%** of the cost
• Specialist's office	**$25** copay	**50%** of the cost
Speech therapy		
• Comprehensive outpatient rehab facility	**$25** copay	**50%** of the cost
• Outpatient hospital	**$25** copay	**50%** of the cost
• Specialist's office	**$25** copay	**50%** of the cost
Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD)		
• Outpatient hospital	**$20** copay	**50%** of the cost
• Specialist's office	**$20** copay	**50%** of the cost

Humana.