



Peoples Health Group Medicare HMO-POS



	Group Medicare (HMO-POS)	
	In-Network	Out-of-Network
Maximum Out-of-Pocket Costs	\$2,500	N/A
Out-of-Network Deductible <i>Applies to most out-of-network services</i>	N/A	\$2,000
Doctor Visits & NurseLine		
Primary Care Provider Visit	\$5	20% coinsurance
Specialist Visit*	\$25	20% coinsurance
Telehealth Visit	\$0	Available through contracted provider
24-Hour NurseLine	\$0	
Preventive Care*		
Pap Smears, Pelvic Exams, Mammograms	\$0	20% coinsurance
Prostate & Colorectal Cancer Screenings	\$0	20% coinsurance
Bone Mass Measurement	\$0	20% coinsurance
Vaccinations (COVID-19, flu, pneumonia)	\$0	\$0
Labs & Tests*		
Lab Services	\$0	20% coinsurance
Diagnostic Procedures/Tests	\$0	20% coinsurance
X-rays	\$0	20% coinsurance
Advanced Imaging (MRI, MRA, CT, CTA, PET scans, etc.)	\$0	20% coinsurance
Outpatient Surgery		
Surgery (outpatient hospital or ambulatory surgical center)	\$0	20% coinsurance
Inpatient Hospital Care per Admission		
Inpatient Stay per Day	\$50 days 1-10 \$0 days 11	\$0 days 1-60 \$419 days 61-90 \$838 days 91-150+
Worldwide Emergency Care, Urgent Care and Emergency Transportation*		
Emergency Care	\$50	\$50
Urgently Needed Care	\$10	\$10
Emergency Ambulance Services (per one-way trip, ground or air)	\$50	\$50
Emergency or Urgent Care Outside U.S.	N/A	\$50

*Some network services—including specialist visits, physical therapy, speech therapy and occupational therapy—require a referral from your primary care provider (PCP) to be covered. The PCP you choose can impact which specialists and hospitals you'll be able to see.

*These are 2025 Medicare cost-sharing amounts and may change for 2026; 2026 values are not yet released.

*Emergency care copay waived if admitted to inpatient hospital care within 24 hours for the same condition

Home Health & Skilled Nursing Facility Care		
Home Health Care	\$0	20% coinsurance
Skilled Nursing Facility Care per Day (semiprivate room and board)	\$0 days 1-20 \$25 days 21+	\$0 days 1-20 \$25 days 21+
Outpatient Services & Supplies		
Occupational, Physical or Speech Therapy Visit*	\$0	20% coinsurance
Durable Medical Equipment - DME (wheelchairs, oxygen, etc.)	5% coinsurance	20% coinsurance
Diabetes Monitoring Supplies (DME provider or retail pharmacy)	\$0	20% coinsurance
Mental Health & Substance Abuse Treatment		
Inpatient Mental Health Care (per day)	\$50 days 1-10 \$0 days 11-90	\$0 days 1-60 \$419 days 61-90 \$838 days 91-150 [†]
Outpatient Mental Health Visit or Substance Abuse Treatment Visit	\$10	20% coinsurance
Additional Benefits Not Covered by Medicare		
Allowance for Over-the-Counter Health & Wellness Items	\$40 per quarter	
Meals After Inpatient Hospital Stay (up to 28 meals over 14 days)	\$0	
Routine Eye Exam (one per year)	\$0	
Eyeglasses (one pair per year) or Contact Lenses	\$200 allowance	
Hearing Aids (up to two per year; includes OTC and prescription hearing aids)	\$750 allowance	
Dental - Preventive [§] (oral exams, cleanings and X-rays)	\$0	
Dental - Comprehensive/Restorative	Not covered	
Dental - Coverage Maximum	\$0—there is no dental maximum	
Respite Care (12 sessions per year for members with dementia, including Alzheimer's disease)	\$0	
Fitness Benefit	\$0	
Emergency Medical Alert Device	\$0	

Part D Prescription Drug Coverage

Deductible Stage	\$200 deductible for all tiers	
Initial Coverage Stage	30-Day Supply	90-Day Supply
Tier 1	\$3	\$0
Tier 2	\$10	\$0
Tier 3	\$25	\$50
Tier 4	\$50	\$100
Tier 5	20% coinsurance	20% coinsurance

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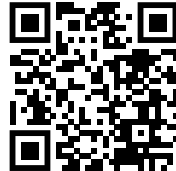
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