2022

Summary of Benefits

FRS

Humana Group Medicare Advantage HMO Plan
HMO 076/135

Humana.

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SB076135N22

Our service area includes the following: **Florida**: Miami-Dade.

Let's talk about the **Humana Group Medicare Advantage HMO** Plan.

Find out more about the Humana Group Medicare Advantage HMO plan – including the services it covers – in this easy-to-use guide.

The benefit information provided is a summary of what we cover and what you pay. 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".

To be eligible

To join the Humana Group Medicare Advantage HMO plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Plan name:

Humana Group Medicare Advantage HMO plan

How to reach us:

Members should call toll-free **1-866-396-8810** for questions **(TTY/TDD 711)**

Call Monday – Friday, 8 a.m. - 9 p.m. Eastern Time.

Or visit our website: **Humana.com**

Humana Group Medicare Advantage HMO plan has a network of doctors, hospitals, and other providers. For more information, please call Group Medicare Customer Care.

A healthy partnership

Get more from your plan — with extra services and resources provided by Humana!

Monthly Premium, Deductible and Limits

	IN-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 Humana, your employer/union group, or your employer group benefits plan administrator.
Medical deductible	This plan does not have a deductible.
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; Acupuncture (Routine); COVID-19 Testing; COVID-19 Treatment; Dental Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Hyperbaric Oxygen Treatment; Meal Benefit; OTC Drugs and Supplies; Podiatry Services (Routine); Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Sleep Study (Facility Based); Sleep Study (Home Based); Smoking Cessation (Additional); Transportation (Routine); Vision Services (Routine); Wound Care and the Plan Premium. 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.

Covered Medical and Hospital Benefits

	IN-NETWORK
ACUTE INPATIENT HOSPITAL CARE	
Our 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
OUTPATIENT HOSPITAL COVERAGE	
Outpatient hospital visits	**$0** to **$75** copay or **20%** of the cost
Ambulatory surgical center	**$0** copay
Hyperbaric oxygen treatment visits	**$75** copay
Wound care visits	**$75** copay

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

Covered Medical and Hospital Benefits

	IN-NETWORK
DOCTOR OFFICE VISITS	
Primary care provider (PCP)	**$0** copay
Specialists	**$0** 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**
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.	**$50** 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.	**$0** copay
DIAGNOSTIC SERVICES, LABS AND IMAGING	
Diagnostic radiology	**$0** to **$25** copay
Lab services	**$0** to **$12** copay
Diagnostic tests and procedures	**$0** to **$20** copay
Outpatient X-rays	**$0** to **$20** copay
Radiation therapy	**$25** copay

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

Covered Medical and Hospital Benefits

	IN-NETWORK
HEARING SERVICES	
Medicare-covered hearing	**$20** copay
Routine hearing HearUSA provider must be used. Contact Customer Service to locate a provider.	**$0** copay for fitting/evaluation, routine hearing exams up to 1 per year. **$1,000** maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year. Note: Includes 1 month battery supply and 1 year warranty.
DENTAL SERVICES	
Medicare-covered dental	**$20** copay
Routine dental	**$0** copay for periodontal scaling and root planing up to 1 per quadrant every 3 years. **$0** copay for complete or partial dentures up to 1 set every 5 years. **$0** copay for denture reline, panoramic film or diagnostic x-rays, root canal, scaling for moderate inflammation up to 1 per year. **$0** copay for bitewing x-rays up to 2 set(s) per year. **$0** copay for crown, periodic oral exam and/or comprehensive oral evaluation, prophylaxis (cleaning) up to 2 per year. **$0** copay for amalgam and/or composite filling, periodontal maintenance up to 4 per year. **$0** copay for necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year.
VISION SERVICES	
Medicare-covered vision services	**$0** copay
Medicare-covered diabetic eye exam	**$0** copay
Medicare-covered glaucoma screening	**$0** copay
Medicare-covered eyewear (post-cataract)	**$0** copay
Routine vision	**$0** copay for routine exam up to 1 per year. **$400** maximum benefit coverage amount per year for contact lenses, eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames or 3 pairs of select eyeglasses at no cost. Eyeglasses include ultraviolet protection and scratch resistant coating.

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

Covered Medical and Hospital Benefits

	IN-NETWORK
MENTAL HEALTH SERVICES	
Inpatient The inpatient hospital care limit applies to inpatient mental services provided in a general hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. 190 day lifetime limit in a psychiatric facility	**$0** per admit
Outpatient group and individual therapy visits	**$0** to **$12** copay
SKILLED NURSING FACILITY	
Our 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 1-20 **$50** copay per day for days 21-100
PHYSICAL THERAPY	
	$0 to **$20** copay
AMBULANCE	
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	**$75** copay
TRANSPORTATION	
	$0 copay for plan approved location up to unlimited one-way trip(s) per year.
PART B PRESCRIPTION DRUGS	
	0% of the cost

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

Covered Medical and Hospital Benefits

	IN-NETWORK
ACUPUNCTURE SERVICES	
Medicare-covered acupuncture **20** 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.	**$0** copay
Routine acupuncture **25** visit limit per plan year	**$0** copay
ALLERGY	
Allergy shots & serum	**$0** copay
CHIROPRACTIC SERVICES	
Medicare-covered chiropractic visit(s)	**0%** of the cost
COVID-19	
Testing and Treatment	**$0** copay for testing and treatment services for COVID-19
DIABETES MANAGEMENT TRAINING	
	$0 copay
FOOT CARE (PODIATRY)	
Medicare-covered foot care	**$0** copay
Routine foot care **Unlimited** visit limit per plan year	**$0** copay
HOME HEALTH CARE	
	$0 copay
MEDICAL EQUIPMENT/SUPPLIES	
Durable medical equipment (like wheelchairs or oxygen)	**0%** of the cost
Medical supplies	**$0** copay
Prosthetics (artificial limbs or braces)	**$0** copay
Diabetes monitoring supplies	**0%** of the cost

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

	IN-NETWORK
OUTPATIENT SUBSTANCE ABUSE	
Outpatient group and individual substance abuse treatment visits	**$0** to **$12** copay
OVER-THE-COUNTER ITEMS	
	$75 maximum benefit coverage amount per month for select over-the-counter health and wellness products.
REHABILITATION SERVICES	
Occupational and speech therapy	**$0** to **$20** copay
Cardiac rehabilitation	**$0** copay
Pulmonary rehabilitation	**$0** to **$20** copay
RENAL DIALYSIS	
Renal dialysis	**20%** of the cost
Kidney disease education services	**$0** copay
SLEEP STUDY	
	$0 to **$75** copay
TELEHEALTH SERVICES (in addition to Original Medicare)	
Primary care provider (PCP)	**$0** copay
Specialist	**$0** copay
Urgent care services	**$0** copay
Substance abuse or behavioral health services	**$0** copay
THERAPEUTIC SHOES AND INSERTS	
	0% of the cost
FITNESS AND WELLNESS	
	SilverSneakers® Fitness Program - Basic fitness center membership including fitness classes.
HOSPICE You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.	

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

Notes

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-866-396-8810** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-866-396-8810 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you.
1-866-396-8810 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d’aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani’í bee wolta’ígíí bich’į’ hódíílnih éí bee t’áá jiik’eh saad bee áká’ánída’áwo’déé’ niká’adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

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Find out **more**

You can see your plan's provider directory at **Humana.com** or call us at the number listed at the beginning of this booklet and we will send you one.

Humana is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

If you want to compare our plan with other Medicare health plans, you can call your employer or union sponsoring this plan to find out if you have other options through them.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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