

2022

# Summary of Benefits

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**Humana Group Medicare Advantage PPO Plan  
PPO 079/187**

**Humana®**

Our service area includes the following: **Arizona:** Cochise, Graham, Greenlee, Maricopa, Pima, Pinal, Santa Cruz; **Colorado:** Adams, Alamosa, Arapahoe, Archuleta, Bent, Boulder, Broomfield, Chaffee, Clear Creek, Conejos, Costilla, Crowley, Custer, Delta, Denver, Dolores, Douglas, El Paso, Elbert, Fremont, Gilpin, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Jefferson, La Plata, Lake, Larimer, Las Animas, Lincoln, Logan, Mesa, Mineral, Montezuma, Montrose, Morgan, Otero, Ouray, Park, Pueblo, Rio Blanco, Rio Grande, Saguache, San Juan, San Miguel, Summit, Teller, Washington, Weld; **Florida:** Brevard, Broward, Glades, Hendry, Indian River, Martin, Miami-Dade, Okeechobee, Palm Beach, Saint Lucie; **Illinois:** Adams, Christian, Clark, Edgar, Henry, Jasper, Macon, Menard, Mercer, Morgan, Moultrie, Pike, Richland, Rock Island, Sangamon, Scott, Vermilion; **North Dakota:** Barnes, Burleigh, Cass, Grand Forks, Kidder, Morton, Richland, Stutsman, Traill; **Oklahoma:** Adair, Blaine, Bryan, Caddo, Canadian, Carter, Cherokee, Choctaw, Cleveland, Comanche, Craig, Creek, Delaware, Dewey, Garfield, Garvin, Grady, Haskell, Hughes, Jackson, Johnston, Kay, Kingfisher, Kiowa, Latimer, Le Flore, Lincoln, Logan, Mayes, McClain, McCurtain, McIntosh, Murray, Muskogee, Noble, Nowata, Okfuskee, Oklahoma, Okmulgee, Osage, Ottawa, Pawnee, Payne, Pittsburg, Pontotoc, Pottawatomie, Pushmataha, Rogers, Seminole, Sequoyah, Stephens, Tulsa, Wagoner, Woodward; **Pennsylvania:** Bucks, Chester, Delaware, Montgomery, Northumberland, Philadelphia; **Puerto Rico:** Adjuntas, Aguada, Aguadilla, Aguas Buenas, Aibonito, Anasco, Arecibo, Arroyo, Barceloneta, Barranquitas, Bayamon, Cabo Rojo, Caguas, Camuy, Canovanas, Carolina, Catano, Cayey, Ceiba, Ciales, Cidra, Coamo, Comerio, Corozal, Culebra, Dorado, Fajardo, Florida, Guanica, Guayama, Guayanilla, Guaynabo, Gurabo, Hatillo, Hormigueros, Humacao, Isabela, Jayuya, Juana Diaz, Juncos, Lajas, Lares, Las Marias, Las Piedras, Loiza, Luquillo, Manati, Maricao, Maunabo, Mayaguez, Moca, Morovis, Naguabo, Naranjito, Orocovi, Patillas, Penuelas, Ponce, Quebradillas, Rincon, Rio Grande, Sabana Grande, Salinas, San German, San Juan, San Lorenzo, San Sebastian, Santa Isabel, Toa Alta, Toa Baja, Trujillo Alto, Utuado, Vega Alta, Vega Baja, Vieques, Villalba, Yabucoa, Yauco; **South Dakota:** Bon Homme, Brookings, Butte, Clark, Clay, Codington, Custer, Davison, Day, Deuel, Fall River, Grant, Hamlin, Hanson, Hutchinson, Kingsbury, Lake, Lawrence, Lincoln, Marshall, Mccook, Meade, Miner, Minnehaha, Moody, Pennington, Roberts, Sanborn, Spink, Turner, Union, Yankton; **Wisconsin:** Ashland, Buffalo, Clark, Douglas, Iron, Jackson, Pepin, Pierce, Price, Saint Croix, Taylor, Trempealeau, Vilas.



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

Find out more about the Humana Group Medicare Advantage PPO 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".

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## **To be eligible**

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

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

## **Plan name:**

Humana Group Medicare Advantage PPO 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**



## **A healthy partnership**

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

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# Monthly Premium, Deductible and Limits

## IN-NETWORK

## OUT-OF-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

**\$4,500** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; COVID-19 Testing; COVID-19 Treatment; Dental Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; OTC Drugs and Supplies; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Vision Services (Routine) 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.

#### Combined In and Out-of-Network Maximum Out-of-Pocket

**\$6,700** out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy; COVID-19 Testing; COVID-19 Treatment; Dental Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; OTC Drugs and Supplies; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Vision Services (Routine) and the Plan Premium do not apply to the combined maximum out-of-pocket.

Out-of-Network Exclusions: Part D Pharmacy; COVID-19 Testing; COVID-19 Treatment; Dental Services (Routine); Hearing Services (Routine); Vision Services (Routine); Worldwide Coverage and the Plan Premium do not apply to the combined maximum out-of-pocket.

Your limit for services received from in-network providers will count toward this limit.

If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the

**Note:** some services require prior authorization.



## Monthly Premium, Deductible and Limits

### IN-NETWORK

### OUT-OF-NETWORK

year on covered hospital and medical services.



## Covered Medical and Hospital Benefits

### IN-NETWORK

### OUT-OF-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.

**\$250** copay per day for days 1-5

**\$295** copay per day for days 1-5

#### OUTPATIENT HOSPITAL COVERAGE

##### Outpatient hospital visits

**\$35** to **\$250** copay or **20%** of the cost

**\$65** copay or **20%** to **50%** of the cost

##### Ambulatory surgical center

**\$150** copay

**50%** of the cost

##### Wound care visits

**\$35** copay

**\$65** copay

#### DOCTOR OFFICE VISITS

##### Primary care provider (PCP)

**\$0** copay

**\$65** copay

##### Specialists

**\$35** copay

**\$65** 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**

**\$0** copay or **0%** to **50%** of the cost for Medicare-covered preventive services

**50%** of the cost for a supplemental annual physical exam

**Note:** some services require prior authorization.



# Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>EMERGENCY CARE</b>		
<b>Emergency room</b> 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.	<b>\$90</b> copay for Medicare-covered emergency room visit(s)	<b>\$90</b> copay for Medicare-covered emergency room visit(s)
<b>Urgently needed services</b> Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	<b>\$0 to \$35</b> copay	<b>\$65</b> copay
<b>DIAGNOSTIC SERVICES, LABS AND IMAGING</b>		
<b>Diagnostic radiology</b>	<b>\$150 to \$250</b> copay	<b>50%</b> of the cost
<b>Lab services</b>	<b>\$0 to \$15</b> copay or <b>20%</b> of the cost	<b>\$65</b> copay or <b>50%</b> of the cost
<b>Diagnostic tests and procedures</b>	<b>\$0 to \$35</b> copay or <b>20%</b> of the cost	<b>\$65</b> copay or <b>50%</b> of the cost
<b>Outpatient X-rays</b>	<b>\$0 to \$35</b> copay or <b>20%</b> of the cost	<b>\$65</b> copay or <b>50%</b> of the cost
<b>Radiation therapy</b>	<b>\$35</b> copay or <b>20%</b> of the cost	<b>\$65</b> copay or <b>50%</b> of the cost
<b>HEARING SERVICES</b>		
<b>Medicare-covered hearing</b>	<b>\$35</b> copay	<b>\$65</b> copay
<b>Routine hearing</b>	<b>\$0</b> copay for routine hearing exams up to 1 per year.	<b>\$0</b> copay for routine hearing exams up to 1 per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
<b>DENTAL SERVICES</b>		
<b>Medicare-covered dental</b>	<b>\$35</b> copay	<b>\$65</b> copay
<b>Routine dental</b>	<b>\$0</b> copay for bitewing x-rays up to 1 set(s) per year.	<b>\$0</b> copay for bitewing x-rays up to 1 set(s) per year.

**Note:** some services require prior authorization.



# Covered Medical and Hospital Benefits

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
	<b>\$0</b> copay for amalgam filling, oral evaluation, prophylaxis (cleaning) up to 1 per year.	<b>\$0</b> copay for amalgam filling, oral evaluation, prophylaxis (cleaning) up to 1 per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
<b>VISION SERVICES</b>		
<b>Medicare-covered vision services</b>	<b>\$35</b> copay	<b>\$65</b> copay
<b>Medicare-covered diabetic eye exam</b>	<b>\$0</b> copay	<b>\$65</b> copay
<b>Medicare-covered glaucoma screening</b>	<b>\$0</b> copay	<b>50%</b> of the cost
<b>Medicare-covered eyewear (post-cataract)</b>	<b>\$0</b> copay	<b>0%</b> of the cost
<b>Routine vision</b>	<b>\$40</b> combined maximum benefit coverage amount per year for routine exam (includes refraction) up to 1 per year. <b>\$100</b> combined maximum benefit coverage amount per year for contact lenses, eyeglasses-lenses and frames.	<b>\$40</b> combined maximum benefit coverage amount per year for routine exam (includes refraction) up to 1 per year. <b>\$100</b> combined maximum benefit coverage amount per year for contact lenses, eyeglasses-lenses and frames. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

**Note:** some services require prior authorization.



# Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>MENTAL HEALTH SERVICES</b>		
<b>Inpatient</b> 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	<b>\$250</b> copay per day for days 1-5	<b>\$295</b> copay per day for days 1-5
<b>Outpatient group and individual therapy visits</b>	<b>\$0</b> to <b>\$35</b> copay or <b>20%</b> of the cost	<b>\$65</b> copay or <b>50%</b> of the cost
<b>SKILLED NURSING FACILITY</b>		
Our plan covers up to 100 days in a SNF.  No 3-day hospital stay is required. Plan pays \$0 after 100 days	<b>\$0</b> copay per day for days 1-20 <b>\$160</b> copay per day for days 21-100	<b>\$250</b> copay per day for days 1-58 <b>\$0</b> copay per day for days 59-100
<b>PHYSICAL THERAPY</b>		
	<b>\$10</b> to <b>\$35</b> copay	<b>\$65</b> copay or <b>50%</b> of the cost
<b>AMBULANCE</b>		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	<b>\$240</b> copay	<b>\$240</b> copay
<b>PART B PRESCRIPTION DRUGS</b>		
	<b>20%</b> of the cost	<b>20%</b> of the cost

**Note:** some services require prior authorization.





# Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>ACUPUNCTURE SERVICES</b>		
<b>Medicare-covered acupuncture</b>	<b>\$35</b> copay	<b>\$65</b> copay
<p><b>20</b> combined In &amp; Out-of-Network visit limit per plan year</p> <p>Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements.</p>		
<b>ALLERGY</b>		
<b>Allergy shots &amp; serum</b>	<b>\$0</b> copay	<b>0%</b> of the cost
<b>CHIROPRACTIC SERVICES</b>		
<b>Medicare-covered chiropractic visit(s)</b>	<b>\$20</b> copay	<b>\$65</b> copay
<b>COVID-19</b>		
<b>Testing and Treatment</b>	<b>\$0</b> copay for testing and treatment services for COVID-19	
<b>DIABETES MANAGEMENT TRAINING</b>		
	<b>\$0</b> copay	<b>50%</b> of the cost
<b>FOOT CARE (PODIATRY)</b>		
<b>Medicare-covered foot care</b>	<b>\$35</b> copay	<b>\$65</b> copay
<b>HOME HEALTH CARE</b>		
	<b>\$0</b> copay	<b>50%</b> of the cost
<b>MEDICAL EQUIPMENT/SUPPLIES</b>		
<b>Durable medical equipment (like wheelchairs or oxygen)</b>	<b>20%</b> of the cost	<b>30%</b> of the cost
<b>Medical supplies</b>	<b>20%</b> of the cost	<b>25%</b> of the cost
<b>Prosthetics (artificial limbs or braces)</b>	<b>20%</b> of the cost	<b>25%</b> of the cost
<b>Diabetes monitoring supplies</b>	<b>0%</b> of the cost	<b>50%</b> of the cost
<b>OUTPATIENT SUBSTANCE ABUSE</b>		
<b>Outpatient group and individual substance abuse treatment visits</b>	<b>\$0 to \$35</b> copay or <b>20%</b> of the cost	<b>\$65</b> copay or <b>50%</b> of the cost

**Note:** some services require prior authorization.



# Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>OVER-THE-COUNTER ITEMS</b>		
	\$75 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products.	
<b>REHABILITATION SERVICES</b>		
Occupational and speech therapy	\$10 to \$35 copay	\$65 copay or 50% of the cost
Cardiac rehabilitation	\$35 copay	\$65 copay or 50% of the cost
Pulmonary rehabilitation	\$10 to \$30 copay	\$65 copay or 50% of the cost
<b>RENAL DIALYSIS</b>		
Renal dialysis	20% of the cost	20% of the cost
Kidney disease education services	\$0 copay	50% of the cost
<b>SLEEP STUDY</b>		
	\$0 to \$200 copay or 20% of the cost	50% of the cost
<b>TELEHEALTH SERVICES (in addition to Original Medicare)</b>		
Primary care provider (PCP)	\$0 copay	Not Covered
Specialist	\$35 copay	Not Covered
Urgent care services	\$0 copay	Not Covered
Substance abuse or behavioral health services	\$0 copay	Not Covered
<b>THERAPEUTIC SHOES AND INSERTS</b>		
	\$10 copay	50% of the cost
<b>FITNESS AND WELLNESS</b>		
	SilverSneakers® Fitness Program - Basic fitness center membership including fitness classes.	
<b>HOSPICE</b>		
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.

# 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):** Wóda hí béésh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá jii'k'eh saad bee áká'ánída'áwo'déé nika'adoowoł.

**العربية (Arabic)**

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك



## Find out **more**

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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 PPO 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.

**Humana**<sup>®</sup>

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