2021

PLEASE BE AWARE THAT THIS IS JUST A BRIEF SUMMARY OF YOUR BENEFITS WITH THE HUMANA MEDICARE ADVANTAGE PLAN. THIS SUMMARY WILL BE INCLUDED IN YOUR HUMANA KIT THAT YOU WILL RECEIVE IN EARLY NOVEMBER.
A MORE DETAILED DESCRIPTION OF BENEFITS WILL BE INCLUDED WHEN YOUR ID CARD IS MAILED TO YOU LATER.
ALSO, PLEASE NOTE THAT THE CO-PAY RANGE YOU SEE ON THIS SUMMARY IS LISTED TO MAKE YOU AWARE THAT YOUR OUT OF POCKET EXPENSE CAN VARY DEPENDING UPON LOCATION/FACILITY WHERE YOU HAVE CERTAIN PROCEDURES PERFORMED.

Summary of Benefits

Humana Group Medicare Advantage PPO Plan
PPO 079/209

County of Rensselaer

Humana®

Our service area includes specific counties within the United States, Puerto Rico and the Virgin Islands.

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".

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.

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**

Humana Group Medicare Advantage PPO 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	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 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** **$3,400** 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 Care Package ; COVID-19 Testing ; COVID-19 Treatment ; Dental Services (Routine) ; Fitness Program ; Health Education Services ; Hearing Services (Routine) ; Meal Benefit ; 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** **$3,400** out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy, COVID-19 Care Package ; COVID-19 Testing ; COVID-19 Treatment ; Dental Services (Routine) ; Fitness Program ; Health Education Services ; Hearing Services (Routine) ; Meal Benefit ; 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.	**$0** per admit	**$0** per admit
OUTPATIENT HOSPITAL COVERAGE		
Outpatient hospital visits	**$0** to **$20** copay	**$0** to **$20** copay
Ambulatory surgical center	**$0** copay	**$0** copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$10** copay	**$10** copay
Specialists	**$15** copay	**$15** 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 for Medicare-covered preventive services **$0** copay for a supplemental annual physical exam
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.	**$75** copay for Medicare-covered emergency room visit(s)	**$75** copay for Medicare-covered emergency room visit(s)

Note: *some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
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.	**$10** to **$25** copay	**$10** to **$25** copay
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic radiology	**$10** to **$15** copay	**$10** to **$15** copay
Lab services	**$0** copay	**$0** copay
Diagnostic tests and procedures	**$0** to **$25** copay	**$0** to **$25** copay
Outpatient X-rays	**$10** to **$25** copay	**$10** to **$25** copay
Radiation therapy	**$15** copay	**$15** copay
HEARING SERVICES		
Medicare-covered hearing	**$15** copay	**$15** copay
Routine hearing	• $0 copay for routine hearing exams up to 1 every 3 years. • $600 combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 every 3 years.	• $0 copay for routine hearing exams up to 1 every 3 years. • $600 combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 every 3 years. • 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
DENTAL SERVICES		
Medicare-covered dental	**$15** copay	**$15** copay
Routine dental	• $250 combined maximum benefit coverage amount per year for preventive benefits including bitewing x-rays, fluoride treatment, intraoral x-rays, panoramic film or diagnostic x-rays up to 1 per year and periodic oral exam and/or comprehensive oral evaluation, prophylaxis (cleaning) up to 2 per year.	• $250 combined maximum benefit coverage amount per year for preventive benefits including bitewing x-rays, fluoride treatment, intraoral x-rays, panoramic film or diagnostic x-rays up to 1 per year and periodic oral exam and/or comprehensive oral evaluation, prophylaxis (cleaning) up to 2 per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
VISION SERVICES		
Medicare-covered vision services	**$15** copay	**$15** copay
Medicare-covered diabetic eye exam	**$0** copay	**$0** copay
Medicare-covered glaucoma screening	**$0** copay	**$0** copay
Medicare-covered eyewear (post-cataract)	**$15** copay	**$15** copay
Routine vision	• $0 copay for refraction, routine exam up to 1 per year. • $100 combined maximum benefit coverage amount per year for contact lenses, eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.	• $0 copay for refraction, routine exam up to 1 per year. • $100 combined maximum benefit coverage amount per year for contact lenses, eyeglasses-lenses and frames, fitting for 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
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	**$0** per admit
Outpatient group and individual therapy visits	**$10** to **$25** copay	**$10** to **$25** 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 1-100	**$0** copay per day for days 1-100
PHYSICAL THERAPY		
	$15 copay	**$15** copay
AMBULANCE		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	**$100** copay	**$100** copay
PART B PRESCRIPTION DRUGS		
	$0 to **$20** copay	**$0** to **$20** copay
ACUPUNCTURE SERVICES		
Medicare-covered acupuncture	**$15** copay Limit 20 visit(s) per year	**$15** copay Limit 20 visit(s) per year
ALLERGY		
Allergy shots & serum	**$10** to **$15** copay	**$10** to **$15** copay
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	**$15** copay	**$15** copay

Note: *some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
COVID-19		
Testing and Treatment	**$0** copay for testing and treatment services for COVID-19	
Health Essentials Kit	Kit includes over the counter items useful for preventing the spread of COVID-19 and other viruses. Limited one per year.	
DIABETES MANAGEMENT TRAINING		
	$0 copay	**$0** copay
FOOT CARE (PODIATRY)		
Medicare-covered foot care	**$15** copay	**$15** copay
HOME HEALTH CARE		
	$0 copay	**$0** copay
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**$20** copay or **20%** of the cost	**$20** copay or **20%** of the cost
Medical supplies	**$20** copay or **20%** of the cost	**$20** copay or **20%** of the cost
Prosthetics (artificial limbs or braces)	**20%** of the cost	**20%** of the cost
Diabetes monitoring supplies	**$0** copay or **20%** of the cost	**$0** copay or **20%** of the cost
OUTPATIENT SUBSTANCE ABUSE		
Outpatient group and individual substance abuse treatment visits	**$10** to **$25** copay	**$10** to **$25** copay
REHABILITATION SERVICES		
Occupational and speech therapy	**$15** copay	**$15** copay
Cardiac rehabilitation	**$15** copay	**$15** copay
Pulmonary rehabilitation	**$15** copay	**$15** copay
RENAL DIALYSIS		
Renal dialysis	**$15** copay	**$15** copay
Kidney disease education services	**$0** copay	**$0** copay
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered
Specialist	**$15** copay	Not Covered

Note: *some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered
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.*

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'dęę́ niká'adoowoł.

العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

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 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®

Humana.com