

2021

Summary of Benefits

**Humana Group Medicare Advantage PPO Plan
PPO 079/483**

Michigan State University

Humana®

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



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.

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 **1-800-273-2509** for questions **(TTY/TDD 711)**

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

Or visit our website:
<https://our.humana.com/msu>



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 | \$192 per year for some combined in- and out-of-network services | \$192 per year for some combined in- and out-of-network services |
| Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for medical services for the year. | <p>In-Network Maximum Out-of-Pocket \$1,200 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 ; Fitness Program ; Health Education Services ; Meal Benefit ; Smoking Cessation (Additional) and the Plan Premium.</p> <p>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.</p> | <p>Combined In and Out-of-Network Maximum Out-of-Pocket \$1,200 out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy, COVID-19 Care Package ; COVID-19 Testing ; COVID-19 Treatment ; Fitness Program ; Health Education Services ; Meal Benefit ; Smoking Cessation (Additional) and the Plan Premium do not apply to the combined maximum out-of-pocket.</p> <p>Out-of-Network Exclusions: Part D Pharmacy, COVID-19 Testing ; COVID-19 Treatment ; Worldwide Coverage and the Plan Premium do not apply to the combined maximum out-of-pocket.</p> <p>Your limit for services received from in-network providers will count toward this limit.</p> <p>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.</p> |

Note: some services require prior authorization.



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 copay | \$0 copay |
| Ambulatory surgical center | \$0 copay | \$0 copay |
| DOCTOR OFFICE VISITS | | |
| Primary care provider (PCP) | 4% of the cost | 4% of the cost |
| Specialists | 4% of the cost | 4% of the cost |
| 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. | \$50 copay for Medicare-covered emergency room visit(s) | \$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. | 4% of the cost | 4% of the cost |

Note: some services require prior authorization.



Covered Medical and Hospital Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| DIAGNOSTIC SERVICES, LABS AND IMAGING | | |
| Diagnostic radiology | \$0 copay | \$0 copay |
| Lab services | \$0 copay | \$0 copay |
| Diagnostic tests and procedures | \$0 copay or 4% of the cost | \$0 copay or 4% of the cost |
| Outpatient X-rays | \$0 copay or 4% of the cost | \$0 copay or 4% of the cost |
| Radiation therapy | \$0 copay | \$0 copay |
| HEARING SERVICES | | |
| Medicare-covered hearing | 4% of the cost | 4% of the cost |
| DENTAL SERVICES | | |
| Medicare-covered dental | 4% of the cost | 4% of the cost |
| VISION SERVICES | | |
| Medicare-covered vision services | 4% of the cost | 4% of the cost |
| Medicare-covered diabetic eye exam | 0% of the cost | 0% of the cost |
| Medicare-covered glaucoma screening | \$0 copay | \$0 copay |
| Medicare-covered eyewear (post-cataract) | 4% of the cost | 4% of the cost |
| 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 | \$0 copay or 4% of the cost | \$0 copay or 4% of the cost |

Note: some services require prior authorization.



Covered Medical and Hospital Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|--|
| SKILLED NURSING FACILITY | | |
| Our plan covers up to 100 days in a SNF. | \$0 copay per day for days 1-100 | \$0 copay per day for days 1-100 |
| No 3-day hospital stay is required. Plan pays \$0 after 100 days | | |
| PHYSICAL THERAPY | | |
| | \$0 copay | \$0 copay |
| AMBULANCE | | |
| Per date of service regardless of the number of trips. Limited to Medicare-covered transportation. | 4% of the cost | 4% of the cost |
| PART B PRESCRIPTION DRUGS | | |
| | 0% to 4% of the cost | 0% to 4% of the cost |
| ACUPUNCTURE SERVICES | | |
| Medicare-covered acupuncture | 4% of the cost Limit 20 visit(s) per year | 4% of the cost Limit 20 visit(s) per year |
| ALLERGY | | |
| Allergy shots & serum | 4% of the cost | 4% of the cost |
| CHIROPRACTIC SERVICES | | |
| Medicare-covered chiropractic visit(s) | 4% of the cost | 4% of the cost |
| Routine chiropractic visit(s) | 4% of the cost unlimited visit(s) per year for routine chiropractic services | 4% of the cost unlimited visit(s) per year for routine chiropractic services |
| 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 | 4% of the cost | 4% of the cost |

Note: some services require prior authorization.



Covered Medical and Hospital Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|--|--|-----------------------------|
| HOME HEALTH CARE | | |
| | \$0 copay | \$0 copay |
| MEDICAL EQUIPMENT/SUPPLIES | | |
| Durable medical equipment (like wheelchairs or oxygen) | 0% to 4% of the cost | 0% to 4% of the cost |
| Medical supplies | 0% to 4% of the cost | 0% to 4% of the cost |
| Prosthetics (artificial limbs or braces) | 4% of the cost | 4% of the cost |
| Diabetes monitoring supplies | 4% of the cost | 4% of the cost |
| OUTPATIENT SUBSTANCE ABUSE | | |
| Outpatient group and individual substance abuse treatment visits | \$0 copay or 4% of the cost | \$0 copay or 4% of the cost |
| PRIVATE DUTY NURSING | | |
| | 20% of the cost | 20% of the cost |
| REHABILITATION SERVICES | | |
| Occupational and speech therapy | \$0 copay | \$0 copay |
| Cardiac rehabilitation | \$0 copay | \$0 copay |
| Pulmonary rehabilitation | \$0 copay | \$0 copay |
| RENAL DIALYSIS | | |
| Renal dialysis | \$0 copay | \$0 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 | 4% of the cost | Not Covered |
| 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. | |

Note: some services require prior authorization.



Covered Medical and Hospital Benefits

IN-NETWORK

OUT-OF-NETWORK

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 **1-800-273-2509** 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. 1-800-273-2509 (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.

1-800-273-2509 (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'í béésh bee hani'í bee wolta'ígíí bich'í' hódílnih éí bee t'áá jii'eh saad bee áká'ánida'áwo'déé nika'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 <https://our.humana.com/msu> 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 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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<https://our.humana.com/msu>