2023

Summary of Benefits

Humana Group Medicare Advantage PPO Plan
PPO 079/484

The Pension Boards-United Church of Christ, Inc.

Humana®

Our service area includes specific counties within the United States, Puerto Rico and all other major US Territories.

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 **1-866-733-1872** 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	**$242** per year for some combined in- and out-of-network services	**$242** 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.	**In-Network Maximum Out-of-Pocket** **$2,000** 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); Chiropractic Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Private Duty Nursing; Smoking Cessation (Additional); Vision Services (Routine); Wigs (medically necessary) 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** **$2,000** out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy; Acupuncture (Routine); Chiropractic Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Private Duty Nursing; Smoking Cessation (Additional); Vision Services (Routine); Wigs (medically necessary) and the Plan Premium do not apply to the combined maximum out-of-pocket. Out-of-Network Exclusions: Part D Pharmacy; Acupuncture (Routine); Chiropractic Services (Routine); Hearing Services (Routine); Private Duty Nursing; Vision Services (Routine); Wigs (medically necessary); 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

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
		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	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.	**$272** per admit	**$272** per admit
OUTPATIENT HOSPITAL COVERAGE		
Outpatient hospital visits	**4%** of the cost	**4%** of the cost
Ambulatory surgical center	**4%** of the cost	**4%** of the cost
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 or **0%** of the cost for Medicare-covered preventive services **0%** of the cost 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.	**4%** of the cost for Medicare-covered emergency room visit(s) **$120** Maximum Out-of-Pocket per visit for emergency room services	**4%** of the cost for Medicare-covered emergency room visit(s) **$120** Maximum Out-of-Pocket per visit for emergency room services

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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.	**4%** of the cost	**4%** of the cost
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic radiology	**4%** of the cost	**4%** of the cost
Lab services	**4%** of the cost	**4%** of the cost
Diagnostic tests and procedures	**0%** to **4%** of the cost	**0%** to **4%** of the cost
Outpatient X-rays	**4%** of the cost	**4%** of the cost
Radiation therapy	**4%** of the cost	**4%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**4%** of the cost	**4%** of the cost
Routine hearing	**$0** copay for fitting/evaluation, routine hearing exams up to unlimited per year. **$3,000** 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 fitting/evaluation, routine hearing exams up to unlimited per year. **$3,000** 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.
DENTAL SERVICES		
Medicare-covered dental	**4%** of the cost (services include surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease)	**4%** of the cost (services include surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease)

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
VISION SERVICES		
Medicare-covered vision services	**4%** of the cost (services include diagnosis and treatment of diseases and injuries of the eye)	**4%** of the cost (services include diagnosis and treatment of diseases and injuries of the eye)
Medicare-covered diabetic eye exam	**0%** of the cost	**0%** of the cost
Medicare-covered glaucoma screening	**0%** of the cost	**0%** of the cost
Medicare-covered eyewear (post-cataract)	**4%** of the cost	**4%** of the cost
Routine vision EyeMed is the In-Network provider for the routine vision benefit. Contact Customer Service to locate a provider.	**$40** copay for routine exam (includes refraction) up to 1 per year.	**$135** combined maximum benefit coverage amount per year for routine exam (includes refraction). **$40** copay for routine exam (includes refraction) up to 1 per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
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	**$272** per admit	**$272** per admit
Outpatient group and individual therapy visits	**Outpatient therapy visit:** **4%** of the cost **Partial Hospitalization:** **4%** of the cost	**Outpatient therapy visit:** **4%** of the cost **Partial Hospitalization:** **4%** of the cost

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
SKILLED NURSING FACILITY		
Our plan covers up to 365 days in a SNF. No 3-day hospital stay is required. Plan pays $0 after 365 days	**$0** copay per day for days 1-20 **$34** copay per day for days 21-100 **20%** of the cost per stay for days 101-365	**$0** copay per day for days 1-20 **$34** copay per day for days 21-100 **20%** of the cost per stay for days 101-365
PHYSICAL THERAPY		
	4% of the cost	**4%** of the cost
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		
	4% of the cost	**4%** of the cost
ACUPUNCTURE SERVICES		
Medicare-covered acupuncture visit(s) for chronic low back pain **20** combined In & Out-of-Network 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.	**4%** of the cost	**4%** of the cost
Routine acupuncture **$3,000** combined In & Out-of-Network maximum benefit coverage amount per year	**20%** of the cost	**20%** of the cost
ALLERGY		
Allergy shots & serum	**4%** of the cost	**4%** of the cost

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	**4%** of the cost	**4%** of the cost
Routine chiropractic visit(s) **$2,000** combined In & Out-of-Network maximum benefit coverage amount per year	**20%** of the cost	**20%** of the cost
COVID-19		
Testing and Treatment	Plan specific cost share is applicable to hospitalization, medical services, and FDA approved Rx with confirmed COVID-19 diagnosis.	
DIABETES MANAGEMENT TRAINING		
	0% of the cost	**0%** of the cost
FOOT CARE (PODIATRY)		
Medicare-covered foot care	**4%** of the cost	**4%** of the cost
HOME HEALTH CARE		
	4% of the cost	**4%** of the cost
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**4%** of the cost	**4%** of the cost
Medical supplies	**4%** of the cost	**4%** of the cost
Prosthetics (artificial limbs or braces)	**4%** of the cost	**4%** of the cost
Wigs (medically necessary) **1** combined In & Out-of-Network item limit per plan year	**20%** of the cost	**20%** 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	**4%** of the cost	**4%** of the cost

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
PRIVATE DUTY NURSING		
$5,000 combined In & Out-of-Network maximum benefit coverage amount per year	**20%** of the cost	**20%** of the cost
REHABILITATION SERVICES		
Occupational and speech therapy	**4%** of the cost	**4%** of the cost
Cardiac rehabilitation	**4%** of the cost	**4%** of the cost
Pulmonary rehabilitation	**4%** of the cost	**4%** of the cost
RENAL DIALYSIS		
Renal dialysis	**4%** of the cost	**4%** of the cost
Kidney disease education services	**0%** of the cost	**0%** of the cost
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

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
FITNESS AND WELLNESS		
	SilverSneakers® is a total health and physical activity program that provides access to exercise equipment, group fitness classes, and social events.	
HEALTH EDUCATION SERVICES		
	Personal Health Coaching is an interactive inbound and outreach on-line and telephonic wellness coaching for Medicare participants who elect to participate, for wellness improvement, including weight management, nutrition, exercise, back care, blood pressure management, and blood sugar management.	
MEAL BENEFIT		
	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members are eligible for nutritious meals delivered to their door at no cost.	
POST-DISCHARGE PERSONAL HOME CARE		
	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members may receive assistance performing activities of daily living within the home. Types of assistance include bathing, dressing, toileting, walking, eating and preparing meals.	
POST-DISCHARGE TRANSPORTATION SERVICES		
	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members are provided transportation to plan approved locations by car, van or wheelchair accessible vehicle at no cost.	
SMOKING CESSATION (ADDITIONAL)		
	A comprehensive smoking cessation program available online, email and phone. Personal coaches assist via establishing goals and providing articles and resources to aid in the effort to quit smoking.	
HOSPICE You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.		

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Where you get your vaccines may determine how it is covered

The Medicare Part D portion of your plan covers all commercially available vaccines—except for those covered by Part B—as long as the vaccine is reasonable and necessary to help prevent illness.

Vaccines at your provider's office

The Medicare Part B portion of your plan pays for the following vaccines at your provider's office and at the pharmacy: influenza (flu) vaccine—once per season; pneumococcal vaccines; hepatitis B vaccines for persons at increased risk of hepatitis and vaccines directly related to the treatment of an injury or direct exposure to a disease or condition, such as rabies and tetanus.

Vaccines at a network pharmacy

Some common vaccines that you should get at your pharmacy, not from your provider, are shingles, Tdap and hepatitis A.

Diabetes coverage

Diabetes prescriptions and supplies

Medicare Part B

Generally, Part B covers the services that may affect people with diabetes. Part B also covers certain preventive services for people at risk for diabetes. You must have Part B to get the services and supplies it covers.

- Diabetic testing supplies
- Insulin pumps*
- Continuous glucose monitors (CGM)*
- Insulin administered (or used) in insulin pumps

Medicare Part D

Part D typically covers diabetes supplies used to inject or inhale insulin. You must be enrolled in a Medicare drug plan to get the supplies Part D covers.

- Diabetes medications
- Insulin administered (or used) with syringes or pens
- Syringes, pen needles or other insulin administration devices that are not durable medical equipment (e.g., Omnipod* or VGO)

Diabetic testing supplies

Your Humana Medicare Advantage Plan helps cover a variety of diabetic glucose testing supplies. The following meters along with their test strips and lancets are covered at $0 through CenterWell Pharmacy™.

- CenterWell TRUE METRIX® AIR by Trividia
- Accu-Chek Guide Me® by RocheDiabetes
- Accu-Chek Guide® by RocheDiabetes

To order a meter and supplies from CenterWell Pharmacy, call **888-538-3518 (TTY: 711)**, Monday – Friday, 8 a.m. - 11 p.m., and Sat., 8 a.m. - 6:30 p.m., Eastern time.

Your doctor can also send prescriptions for meters and other testing supplies by fax or e-prescribe.

You can also request a no-cost meter from the manufacturer by calling Roche at **877-264-7263 (TTY: 711)**, or Trividia Health at **866-788-9618 (TTY: 711)**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

*Available through our preferred durable medical equipment vendors, CCS Medical, 877-531-7959 or Edwards Healthcare, 888-344-3434.

2023 enhanced vaccine and insulin coverage

At Humana, we strive to help our members achieve total health so that they may live their best lives, which includes efforts to provide our members with access to more affordable prescription drugs. Helping to further support these initiatives, President Biden signed the Inflation Reduction Act into law on August 16, 2022.

This means that this Humana Group Medicare Advantage prescription drug plan in this booklet may have additional benefits that are not currently described, including reduced out-of-pocket costs for Part D vaccines and this plan's covered insulin. Benefits include:

$0 vaccines

Member cost share of all Part D vaccines listed on the Advisory Committee on Immunization Practices (ACIP) list[1] will be **$0**.

$35 insulin copay

Member cost share of this plan's covered insulin products covered under Part B[2] and Part D will be **no more than $35** for every one-month (up to a 30-day) supply.

Additional information on the 2023 benefit enhancements will be provided as soon as possible.

→ Please check **Humana.com** frequently for updates on these benefit enhancements.

→ If you have questions about these benefit enhancements or general questions about the plan, contact Humana Group Medicare Customer Care.

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[1]For more information regarding the Centers for Disease Control and Prevention's ACIP vaccine recommendations, please go to www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html.

[2]Part B insulin coverage will be no more than $35 for a one-month (up to a 30-day) supply starting July 1, 2023.

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