2020

Summary of Benefits

Humana Medicare Employer™ PPO Plan

PPO 079/417
St. Paul Electrical Workers' Health Plan

Humana®

Our service area includes specific counties within the United States and Puerto Rico. The employer, union or trust determines where they are going to offer the plan.

Let's talk about **Humana Medicare Employer PPO,**

Find out more about the Humana Medicare Employer 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, ask us for the "Evidence of Coverage" or you will receive one after you enroll.

To be eligible

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

Plan name:

Humana Medicare Employer PPO

How to reach us:

Members should call toll-free **1-800-733-9064** for questions **(TTY/TDD 711)**

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

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

Humana Medicare Employer PPO has a network of doctors, hospitals, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. 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** **$3,000** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy, 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, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.	**Combined In and Out-of-Network Maximum Out-of-Pocket** **$3,000** out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy, 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, 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, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.

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

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)	**$0** copay	**$0** copay
Specialists	**$0** copay	**$0** copay
PREVENTIVE CARE		
Including: Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Covered at no cost when you see an in-network provider. Any additional preventive services approved by Medicare during the contract year will be covered.	**Covered at no cost** when you see an in-network provider.	**$0** copay for Medicare-covered preventive services **$0** copay for a supplemental annual physical exam
EMERGENCY CARE		
Emergency room	**$0** copay for Medicare-covered emergency room visit(s)	**$0** 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	**$0** copay
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic radiology	**$0** copay	**$0** copay
Lab services	**$0** copay	**$0** copay
Diagnostic tests and procedures	**$0** copay	**$0** copay

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
Outpatient X-rays	**$0** copay	**$0** copay
Radiation Therapy	**$0** copay	**$0** copay
HEARING SERVICES		
Medicare-covered hearing	**$0** copay	**$0** copay
Routine hearing	$0 copayment for fitting/evaluation, routine hearing exams up to 1 per year. $450 combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 per year.	$0 copayment for fitting/evaluation, routine hearing exams up to 1 per year. $450 combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
DENTAL SERVICES		
Medicare-covered dental	**$0** copay	**$0** copay
VISION SERVICES		
Medicare-covered vision services	**$0** copay	**$0** copay
Diabetic eye exam	**$0** copay	**$0** copay
Eyewear (post-cataract)	**$0** copay	**$0** copay
Routine vision	$0 copayment for routine exam, refraction up to 1 per year. $125 combined maximum benefit coverage amount per year for contact lenses, eyeglasses-lenses and frames. Includes progressive lenses.	$0 copayment for routine exam, refraction up to 1 per year. $125 combined maximum benefit coverage amount per year for contact lenses, eyeglasses-lenses and frames. Includes progressive lenses. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

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

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	Outpatient therapy visit: **$0** copay	**$0** 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		
	$0 copay	**$0** copay
AMBULANCE		
	$0 copay	**$0** copay
TRANSPORTATION		
	Not covered	Not covered
PART B PRESCRIPTION DRUGS		
	$0 copay or **0%** of the cost	**$0** copay or **0%** of the cost
ALLERGY		
Allergy Shots & Serum	**$0** copay	**$0** copay
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	**$0** copay	**$0** copay
DIABETES MANAGEMENT TRAINING		
	$0 copay	**$0** copay

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

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
FOOT CARE (PODIATRY)		
Medicare-covered foot care	**$0** copay	**$0** copay
HOME HEALTH CARE		
	$0 copay	**$0** copay
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**0%** of the cost	**0%** of the cost
Medical Supplies	**0%** of the cost	**0%** of the cost
Prosthetics (artificial limbs or braces)	**0%** of the cost	**0%** of the cost
Diabetes monitoring supplies	**$0** copay	**$0** copay
OUTPATIENT SUBSTANCE ABUSE		
Outpatient group and individual substance abuse treatment visits	Outpatient substance abuse treatment visit: **$0** copay	**$0** copay
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
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.		

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Notes

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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 identity, 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 **1-800-733-9064** 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 the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone 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**.

Auxiliary aids and services, free of charge, are available to you. 1-800-733-9064 (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.

Multi-Language Interpreter Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-733-9064 **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-733-9064 **(TTY: 711)** 注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。 請致電 1-800-733-9064 **(TTY : 711)**。 ... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-733-9064 **(TTY: 711)**.... 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-800-733-9064 **(TTY: 711)** 번으로 전화해 주십시오 .... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-733-9064 **(TTY: 711)**.... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-733-9064 **(телетайп: 711)**.... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-733-9064 **(TTY: 711)**.... ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-733-9064 **(ATS: 711)**.... UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-733-9064 **(TTY: 711)**.... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-733-9064 **(TTY: 711)**.... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-733-9064 **(TTY: 711)**.... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-733-9064 **(TTY: 711)**.... 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-800-733-9064 **(TTY: 711)** まで、お電話にてご連絡ください。...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-733-9064 **(TTY: 711)** تماس بگیرید.

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-733-9064 **(TTY: 711)**....

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-733-9064 **(رقم هاتف الصم والبكم: 711)**.

Find out **more**

You can see our plan's provider directory at our website 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.

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