

2021

Summary of Benefits

**Humana Group Medicare Advantage HMO Plan
HMO 076/654**

ELA - Zafiro

Humana®

Our service area includes all municipalities in Puerto Rico.



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

Find out more about the Humana Group Medicare Advantage HMO 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 HMO 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 HMO 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 HMO plan

How to reach us:

Members should call toll-free
1-866-773-5959 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!



Monthly Premium, Deductible and Limits

IN-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.

Part B premium reduction

Your plan will reduce your Monthly Part B premium by up to **\$100**.

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

\$1,500 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 Care Package ; COVID-19 Testing ; COVID-19 Treatment ; Dental Services (Routine) ; Fitness Program ; Health Education Services ; 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.



Covered Medical and Hospital Benefits

IN-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.

\$25 per admit

OUTPATIENT HOSPITAL COVERAGE

Outpatient hospital visits

\$0 to **\$15** copay

Ambulatory surgical center

\$15 copay

DOCTOR OFFICE VISITS

Primary care provider (PCP)

\$0 copay

Specialists

\$3 copay

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



Covered Medical and Hospital Benefits

IN-NETWORK

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.

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.

\$25 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 to \$3 copay

DIAGNOSTIC SERVICES, LABS AND IMAGING

Diagnostic radiology

\$3 to \$7 copay

Lab services

\$0 copay

Diagnostic tests and procedures

\$0 to \$7 copay

Outpatient X-rays

\$0 to \$7 copay

Radiation therapy

\$3 to \$7 copay

HEARING SERVICES

Medicare-covered hearing

\$3 copay

Routine hearing

- \$0 copay for fitting/evaluation, routine hearing exams up to 1 per year.
- \$250 maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year.

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



Covered Medical and Hospital Benefits

IN-NETWORK

DENTAL SERVICES

Medicare-covered dental

\$3 copay

Routine dental

- 0% of the cost for bitewing x-rays up to 1 set(s) every 2 years.
- 0% of the cost for amalgam or composite filling up to 1 per tooth every 3 years.
- 0% of the cost for intraoral x-rays up to 6 per year.
- 0% of the cost for comprehensive oral exam, panoramic film up to 1 every 3 years.
- 0% of the cost for scaling and root planing (deep cleaning) up to 1 per quadrant per year.
- 0% of the cost for periodic oral exam, prophylaxis (cleaning) up to 2 per year.
- 0% for extractions up to unlimited per year.
- 25% of the cost for crown up to 1 per tooth every 5 years.
- 25% of the cost for complete dentures, partial dentures up to 1 every 5 years.
- 25% of the cost for bridges up to 1 every 5 years.
- 25% of the cost for adjustments to dentures up to unlimited per year.
- 25% for root canal up to unlimited per year.
- \$1500 combined maximum benefit coverage amount per year for adjustments to dentures, complete dentures, partial dentures, crown, major restorative, bridges.

VISION SERVICES

Medicare-covered vision services

\$3 copay

Medicare-covered diabetic eye exam

\$0 copay

Medicare-covered glaucoma screening

\$0 copay

Medicare-covered eyewear (post-cataract)

\$3 copay

Routine vision

- \$0 copay for refraction, routine exam up to 1 per year.
- \$400 maximum benefit coverage amount per year for contact lenses, eyeglasses-lenses and frames.

EyeMed is the In-Network provider for the routine vision benefit. Contact Customer Service to locate a provider.

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



Covered Medical and Hospital Benefits

IN-NETWORK

MENTAL HEALTH SERVICES

Inpatient **\$25** per admit

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

Outpatient group and individual therapy visits **\$0** to **\$25** copay

SKILLED NURSING FACILITY

Our plan covers up to 100 days in a SNF. **\$0** copay per day for days 1-100

No 3-day hospital stay is required.
Plan pays \$0 after 100 days

PHYSICAL THERAPY

\$3 to **\$15** copay

AMBULANCE

Per date of service regardless of the number of trips. **\$0** copay
Limited to Medicare-covered transportation.

TRANSPORTATION

- \$0 copay for plan approved location up to 12 one-way trip(s) per year by taxi, van.

PART B PRESCRIPTION DRUGS

\$0 copay or **0%** of the cost

ACUPUNCTURE SERVICES

Medicare-covered acupuncture **\$3** copay
Limit 20 visit(s) per year

Routine acupuncture **\$0** copay
6 visit(s) per year

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



Covered Medical and Hospital Benefits

IN-NETWORK

ALLERGY

Allergy shots & serum **\$0 to \$3** copay

CHIROPRACTIC SERVICES

Medicare-covered chiropractic visit(s) **\$3** copay

Routine chiropractic visit(s) **\$0** copay
15 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

FOOT CARE (PODIATRY)

Medicare-covered foot care **\$3** copay

HOME HEALTH CARE

\$0 copay

MEDICAL EQUIPMENT/SUPPLIES

Durable medical equipment (like wheelchairs or oxygen) **0%** of the cost

Medical supplies **0%** of the cost

Prosthetics (artificial limbs or braces) **0%** of the cost

Diabetes monitoring supplies **0%** of the cost

OUTPATIENT SUBSTANCE ABUSE

Outpatient group and individual substance abuse treatment visits **\$0 to \$25** copay

OVER-THE-COUNTER ITEMS

\$50 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products.

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



Covered Medical and Hospital Benefits

IN-NETWORK

REHABILITATION SERVICES

Occupational and speech therapy	\$3 to \$15 copay
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Cardiac rehabilitation	\$3 to \$15 copay
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Pulmonary rehabilitation	\$3 to \$15 copay
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RENAL DIALYSIS

Renal dialysis	\$0 copay
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Kidney disease education services	\$0 copay
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TELEHEALTH SERVICES (in addition to Original Medicare)

Primary care provider (PCP)	\$0 copay
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Specialist	\$3 copay
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Urgent care services	\$0 copay
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Substance abuse or behavioral health services	\$0 copay
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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 and referrals from providers.

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Important!

At Humana Health Plans of Puerto Rico, Inc. ("Humana"), it is important you are treated fairly.

Humana 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 **1-866-773-5959** 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>.

Auxiliary aids and services, free of charge, are available to you.
1-866-773-5959 (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.

1-866-773-5959 (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' hódíílnih éí bee t'áá jiik'éh saad bee áká'ánída'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 **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 HMO 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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