2022

Summary of Benefits

Humana Honor (PPO) H5216-174

Northern New Jersey
Select Counties in New Jersey

Humana®

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-833-2364 (TTY: 711)**.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit **Humana.com/medicare** or call **1-800-833-2364 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

Understanding Important Rules

- ☐ You do not pay a separate monthly plan premium for this Humana plan but, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2023.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you may pay a higher co-pay for services received by non-contracted providers.

2022

Summary of Benefits

Humana Honor (PPO) H5216-174

Northern New Jersey
Select Counties in New Jersey

Humana®

Our service area includes the following county/counties in New Jersey: Bergen, Essex, Hudson, Hunterdon, Monmouth, Morris, Ocean, Passaic, Somerset, Sussex, Union, Warren.

Let's talk about Humana Honor (PPO)

Find out more about the Humana Honor (PPO) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Honor (PPO) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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".

To be eligible

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

Plan name:

Humana Honor (PPO)

How to reach us:

If you're a member of this plan, call toll-free: **1-800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-833-2364 (TTY: 711)**.

October 1 - March 31:

Call 7 days a week from 8 a.m. - 8 p.m.

April 1 - September 30:

Call Monday - Friday, 8 a.m. - 8 p.m.

Or visit our website:
Humana.com/medicare

More about Humana Honor (PPO)

Do you have Medicare and Medicaid? If you are a dual-eligible beneficiary enrolled in both Medicare and the state's program, you may not have to pay the medical costs displayed in this booklet.

If you have Medicaid, be sure to show your Medicaid ID card in addition to your Humana membership card to make your provider aware that you may have additional coverage. Your services are paid first by Humana and then by Medicaid.

As a member it's a good idea to select a doctor as your Primary Care Provider (PCP). Humana Honor (PPO) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, you may be subject to higher copayments/coinsurance.

A healthy partnership

Get more from your plan — with extra services and resources provided by Humana!

Monthly Premium, Deductible and Limits

PLAN COSTS	
Monthly plan premium You must keep paying your Medicare Part B premium.	**$0**
Part B premium reduction	Your plan will reduce your Monthly Part B premium by up to **$40**
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.	**$4,500** in-network **$10,000** combined in- and out-of-network

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
	$300 copay per day for days 1-6 **$0** copay per day for days 7-90 Your plan covers an unlimited number of days for an inpatient stay.	**$495** copay per day for days 1-7 **$0** copay per day for days 8-90
OUTPATIENT HOSPITAL COVERAGE		
Outpatient surgery at outpatient hospital	**$300** copay	**$495** copay
Outpatient surgery at ambulatory surgical center	**$250** copay	**$445** copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**$20** copay
Specialists	**$40** copay	**$60** copay

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE		
	Our plan covers many preventive services at no cost when you see an in-network provider including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including flu shots, hepatitis B shots, pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Annual Wellness Visit • Lung cancer screening • Routine physical exam • Medicare diabetes prevention program	**$0** copay Any additional preventive services approved by Medicare during the contract year will be covered.

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
	Any additional preventive services approved by Medicare during the contract year will be covered.	
EMERGENCY CARE		
Emergency room If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	**$90** copay	**$90** copay
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$20** copay at an urgent care center	**20%** of the cost at an urgent care center
OUTPATIENT CARE AND DIAGNOSTIC SERVICES, LABS AND IMAGING Cost share may vary depending on the service and where service is provided		
Diagnostic mammography	**$40** to **$90** copay	**$60** to **$90** copay
Diagnostic radiology	**$0** to **$300** copay	**$20** to **$495** copay
Lab services	**$0** to **$40** copay	**$0** to **$60** copay or **20%** of the cost
Diagnostic tests and procedures	**$0** to **$90** copay	**$20** to **$110** copay or **20%** of the cost
Outpatient X-rays	**$0** to **$90** copay	**$20** to **$110** copay or **20%** of the cost
Radiation therapy	**20%** of the cost	**20%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**$40** copay	**$60** copay

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Routine hearing	**HER944** • **$0** copayment for routine hearing exams up to 1 per year. • **$399** copayment for each Advanced level hearing aid up to 1 per ear per year. • **$699** copayment for each Premium level hearing aid up to 1 per ear per year. Hearing aid purchase includes: • Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models	**HER944** • **$0** copayment for routine hearing exams up to 1 per year. • **$399** copayment for each Advanced level hearing aid up to 1 per ear per year. • **$699** copayment for each Premium level hearing aid up to 1 per ear per year. **You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (for TTY, dial 711).**
DENTAL SERVICES The cost-share indicated below is what you pay for the covered service.		
Medicare-covered dental	**$40** copay	**$60** copay
Routine dental Dental benefits may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**. Use the HumanaDental Medicare network for the Mandatory Supplemental Dental. The provider locator can be found at **Humana.com** > Find a Doctor > from the Search Type drop down select Dental > under Coverage Type select All Dental Networks > enter zip code > from the network drop down select HumanaDental Medicare.	**DEN186** • **0%** coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **0%** coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years. • **0%** coinsurance for bitewing x-rays up to 1 set(s) per year. • **0%** coinsurance for intraoral x-rays up to 1 per year. • **0%** coinsurance for periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **0%** coinsurance for necessary anesthesia with covered service up to unlimited per year. • **50%** coinsurance for amalgam and/or composite filling up to 2 per year.	**DEN186** • **50%** coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **50%** coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years. • **50%** coinsurance for bitewing x-rays up to 1 set(s) per year. • **50%** coinsurance for intraoral x-rays up to 1 per year. • **50%** coinsurance for periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **50%** coinsurance for necessary anesthesia with covered service up to unlimited per year. • **55%** coinsurance for amalgam and/or composite filling up to 2 per year.

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
	• **50%** coinsurance for simple or surgical extraction up to unlimited per year. • **70%** coinsurance for complete dentures, partial dentures up to 1 set(s) every 5 years. • **70%** coinsurance for adjustments to dentures, crown, denture reline up to 1 per year. • **$2000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits.	• **55%** coinsurance for simple or surgical extraction up to unlimited per year. • **75%** coinsurance for complete dentures, partial dentures up to 1 set(s) every 5 years. • **75%** coinsurance for adjustments to dentures, crown, denture reline up to 1 per year. • **$2000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
VISION SERVICES		
Medicare-covered vision services	**$40** copay	**$60** copay
Medicare-covered diabetic eye exam	**$0** copay	**$60** copay
Medicare-covered glaucoma screening	**$0** copay	**$0** copay
Medicare-covered eyewear (post-cataract)	**$0** copay	**$0** copay

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Routine vision Refraction is only covered when billed as part of the routine vision exam. The provider locator for routine vision can be found at **Humana.com** > Find a Doctor > select Vision care icon > Vision coverage through Medicare Advantage plans.	**VIS752** • **$0** copayment for routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for routine exam. • **$200** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year.	**VIS752** • **$0** copayment for routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for routine exam. • **$200** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$300** copay per day for days 1-6 **$0** copay per day for days 7-90	**$495** copay per day for days 1-7 **$0** copay per day for days 8-90
Outpatient group and individual therapy visits Cost share may vary depending on where service is provided.	**$40** to **$100** copay	**$60** to **$100** copay
SKILLED NURSING FACILITY (SNF)		
Your plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$188** copay per day for days 21-100	**20%** of the cost for days 1-100
PHYSICAL THERAPY		
	$40 copay	**$60** copay

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
AMBULANCE		
Ambulance (ground)	**$290** copay per date of service	**$290** copay per date of service
Ambulance (air)	**20%** of the cost	**20%** of the cost
TRANSPORTATION		
	$0 copay for plan approved location up to 24 one-way trip(s) per year. This benefit is not to exceed 25 miles per trip. The member *must* contact transportation vendor to arrange transportation.	

Prescription Drug Benefits

MEDICARE PART B DRUGS		
Chemotherapy drugs	**20%** of the cost	**20%** of the cost
Other Part B drugs	**20%** of the cost	**20%** of the cost
PRESCRIPTION DRUGS		

Your plan covers Part B drugs including, but not limited to, chemotherapy and some drugs administered by your provider. However, this plan does not cover Part D prescription drugs.

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
Medicare-covered foot care (podiatry)	**$40** copay	**$60** copay
Medicare-covered chiropractic services	**$0** copay	**$20** copay
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**20%** of the cost	**20%** of the cost
Medical Supplies	**20%** of the cost	**20%** of the cost
Prosthetics (artificial limbs or braces)	**20%** of the cost	**20%** of the cost
Diabetic monitoring supplies Cost share may vary depending on where service is provided.	**$0** copay or **10%** to **20%** of the cost	**20%** of the cost

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

REHABILITATION SERVICES		
Occupational and speech therapy	**$40** copay	**$60** copay
Cardiac rehabilitation	**$30** copay	**$60** copay
Pulmonary rehabilitation	**$30** copay	**$60** copay
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered
Specialist	**$40** copay	Not Covered
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

COVID-19 Testing and Treatment

$0 copay for testing and treatment services for COVID-19.

Travel Coverage

The PPO national network gives you in-network coverage across the country, so you can see any doctor who accepts the plan terms and conditions. You'll be able to travel with ease or split your time between locations. Visit **Humana.com** or contact Customer Care on the back of your ID card if you need help finding an in-network provider.

Humana Well Dine® Meal Program

Humana's meal program for members following an inpatient stay in the hospital or nursing facility.

Over-the-Counter (OTC) mail order

$60 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products.
Unused quarterly funds carry over to the next quarter and expire at the end of the plan year.

Rewards and Incentives

Go365 by Humana® a Rewards and Incentive program for completing certain preventive health screenings and health and wellness activities.

SilverSneakers® fitness program

Basic fitness center membership including fitness classes.

Find out **more**

You can see our plan's **provider directory** at our website at **humana.com/finder/search** or call us at the number listed at the beginning of this booklet and we will send you one.

To find out more about the coverage and costs of Original Medicare, look in the 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, seven days a week. TTY users should call 1-877-486-2048.

Medicare-covered eye refractions during a specialist medical visit are not covered.

Telehealth services shown are in addition to the Original Medicare covered telehealth. Your cost may be different for Original Medicare telehealth.

Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services are for informational purposes only and should not be construed as medical advice. Please refer to your evidence of coverage for additional details on what your plan may cover or other rules that may apply.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Out-of-network/non-contracted providers are under no obligation to treat Humana members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Humana®

Humana.com

Notes

Notes

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 **1-877-320-1235** 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. 1-877-320-1235 (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.
1-877-320-1235 (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

Humana Honor (PPO)

H5216174000 ENG

Select Counties in New Jersey

Humana.com

H5216174000SB22