

2022

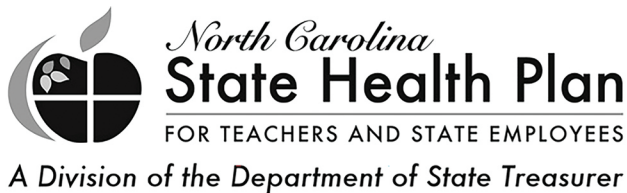
# Summary of Benefits

# Base Plan

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Humana Group Medicare Advantage PPO Plan  
PPO 079/487

North Carolina State Health Plan



*Dale R. Folwell, CPA*  
STATE TREASURER OF NORTH CAROLINA  
DALE R. FOLWELL, CPA

**Humana®**

Our service area covers all 50 states, Puerto Rico, U.S. Virgin Islands and all other major U.S. 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."

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## **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 **1-888-700-2263** for questions **(TTY/TDD 711)**

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

Or visit our website:  
**[our.humana.com/ncshp](https://our.humana.com/ncshp)**



## **A healthy partnership**

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

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## Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
<b>PLAN COSTS</b>		
<b>Monthly premium</b> You must keep paying your Medicare Part B premium.	For information concerning the actual premiums you will pay, please contact the Eligibility and Enrollment Support Center at 1-855-859-0966.	
<b>Medical deductible</b>	This plan does not have a deductible.	
<b>Maximum out-of-pocket responsibility</b> The most you pay for copays, coinsurance and other costs for medical services for the year.	<b>In-Network Maximum Out-of-Pocket</b> <b>\$4,000</b> 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 Testing; COVID-19 Treatment; Fitness Program; Health Education Services; Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Private Duty Nursing; Smoking Cessation (Additional) 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.	<b>Combined In and Out-of-Network Maximum Out-of-Pocket</b> <b>\$4,000</b> out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy; COVID-19 Testing; COVID-19 Treatment; Fitness Program; Health Education Services; Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Private Duty Nursing; Smoking Cessation (Additional) and the Plan Premium do not apply to the combined maximum out-of-pocket.  Out-of-Network Exclusions: Part D Pharmacy; COVID-19 Testing; COVID-19 Treatment; Private Duty Nursing; 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, we will pay the full cost for the rest of the year on covered hospital and medical services.

**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
<b>ACUTE INPATIENT HOSPITAL CARE</b>		
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.	<b>\$160</b> copay per day for days 1-10	<b>\$160</b> copay per day for days 1-10
	<b>\$0</b> copay starting with day 11	<b>\$0</b> copay starting with day 11
<b>OUTPATIENT HOSPITAL COVERAGE</b>		
<b>Outpatient hospital visits</b>	<b>\$20 to \$250</b> copay or <b>20%</b> of the cost	<b>\$20 to \$250</b> copay or <b>20%</b> of the cost
<b>Ambulatory surgical center</b>	<b>\$250</b> copay	<b>\$250</b> copay
<b>DOCTOR OFFICE VISITS</b>		
<b>Primary care provider (PCP)</b>	<b>\$20</b> copay	<b>\$20</b> copay
	<b>\$0</b> copay for virtual visit <b>For virtual visit only:</b> In-network provider must have the ability and be qualified to offer virtual medical visits.	<b>\$0</b> copay for virtual visit <b>For virtual visit only:</b> Out-of-network provider must have the ability and be qualified to offer virtual medical visits.
<b>Specialists</b>	<b>\$40</b> copay	<b>\$40</b> copay
	<b>\$0</b> copay for virtual visit <b>For virtual visit only:</b> In-network provider must have the ability and be qualified to offer virtual medical visits.	<b>\$0</b> copay for virtual visit <b>For virtual visit only:</b> Out-of-network provider must have the ability and be qualified to offer virtual medical visits.
<b>PREVENTIVE CARE</b>		
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.	<b>\$0</b> copay for Medicare-covered preventive services <b>\$0</b> copay for a supplemental annual physical exam	<b>\$0</b> copay for Medicare-covered preventive services <b>\$0</b> copay for a supplemental annual physical exam
<b>EMERGENCY CARE</b>		
<b>Emergency room</b> 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.	<b>\$65</b> copay for Medicare-covered emergency room visit(s)	<b>\$65</b> copay for Medicare-covered emergency room visit(s)

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## Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>Urgently needed services</b> Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	<b>\$20 to \$50</b> copay	<b>\$20 to \$50</b> copay
<b>DIAGNOSTIC SERVICES, LABS AND IMAGING</b>		
<b>Diagnostic radiology</b>	<b>\$0 to \$100</b> copay	<b>\$0 to \$100</b> copay
<b>Lab services</b>	<b>\$0 to \$40</b> copay	<b>\$0 to \$40</b> copay
<b>Diagnostic tests and procedures</b>	<b>\$0 to \$50</b> copay	<b>\$0 to \$50</b> copay
<b>Outpatient X-rays</b>	<b>\$0 to \$50</b> copay	<b>\$0 to \$50</b> copay
<b>Radiation therapy</b>	<b>\$40</b> copay	<b>\$40</b> copay
<b>HEARING SERVICES</b>		
<b>Medicare-covered hearing</b>	<b>\$40</b> copay	<b>\$40</b> copay
<b>Routine hearing</b>	<b>\$0</b> copay for fitting/evaluation, routine hearing exams up to 1 per year.  <b>\$500</b> combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 every 3 years.	<b>\$0</b> copay for fitting/evaluation, routine hearing exams up to 1 per year.  <b>\$500</b> combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 every 3 years.  Benefit received out -of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
<b>DENTAL SERVICES</b>		
<b>Medicare-covered dental</b>	<b>\$40</b> copay	<b>\$40</b> copay
<b>VISION SERVICES</b>		
<b>Medicare-covered vision services</b>	<b>\$40</b> copay	<b>\$40</b> copay
<b>Medicare-covered diabetic eye exam</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>Medicare-covered glaucoma screening</b>	<b>\$0</b> copay	<b>\$0</b> copay

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## Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>Medicare-covered eyewear (post-cataract)</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>Routine vision</b>	<b>\$40</b> copay for routine exam (includes refraction) up to 1 per year.	<b>\$40</b> 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.
<b>MENTAL HEALTH SERVICES</b>		
<b>Inpatient</b> 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	<b>\$140</b> copay per day for days 1-10  <b>\$0</b> copay starting with day 11	<b>\$140</b> copay per day for days 1-10  <b>\$0</b> copay starting with day 11
<b>Outpatient group and individual therapy visits</b>	<b>\$20 to \$50</b> copay	<b>\$20 to \$50</b> copay
<b>SKILLED NURSING FACILITY</b>		
Our plan covers up to 100 days in a SNF.  No 3-day hospital stay is required. Plan pays \$0 after 100 days	<b>\$0</b> copay per day for days 1-20 <b>\$50</b> copay per day for days 21-100	<b>\$0</b> copay per day for days 1-20 <b>\$50</b> copay per day for days 21-100
<b>PHYSICAL THERAPY</b>		
	<b>\$20</b> copay	<b>\$20</b> copay
<b>AMBULANCE</b>		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	<b>\$75</b> copay	<b>\$75</b> copay
<b>PART B PRESCRIPTION DRUGS</b>		
	<b>\$0 to \$50</b> copay	<b>\$0 to \$50</b> copay

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## Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUPUNCTURE SERVICES		
Medicare-covered acupuncture 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.	\$40 copay	\$40 copay
ALLERGY		
Allergy shots & serum	\$0 copay	\$0 copay
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	\$20 copay	\$20 copay
Routine chiropractic visit(s)	\$20 copay	\$20 copay
COVID-19		
Testing and Treatment	\$0 copay for testing and treatment services for COVID-19	
DIABETES MANAGEMENT TRAINING		
	\$0 copay	\$0 copay
FOOT CARE (PODIATRY)		
Medicare-covered foot care	\$40 copay	\$40 copay
Routine foot care 6 combined In & Out-of- Network visit limit per plan year	\$40 copay	\$40 copay
HOME HEALTH CARE		
	\$0 copay	\$0 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

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## Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>Diabetes monitoring supplies</b> Continuous Glucose Monitor (CGM) Medicare-covered Therapeutic Continuous Glucose Monitors (CGMs) and supplies are covered for people with diabetes on intensive insulin therapy	<b>\$0</b> copay	<b>\$0</b> copay
<b>OUTPATIENT SUBSTANCE ABUSE</b>		
<b>Outpatient group and individual substance abuse treatment visits</b>	<b>\$20 to \$50</b> copay	<b>\$20 to \$50</b> copay
<b>PRIVATE DUTY NURSING</b>		
<b>\$5000</b> combined In & Out-of-Network maximum benefit coverage amount per year	<b>20%</b> of the cost	<b>20%</b> of the cost
<b>REHABILITATION SERVICES</b>		
<b>Occupational and speech therapy</b>	<b>\$20</b> copay	<b>\$20</b> copay
<b>Cardiac rehabilitation</b>	<b>\$20</b> copay	<b>\$20</b> copay
<b>Pulmonary rehabilitation</b>	<b>\$20</b> copay	<b>\$20</b> copay
<b>RENAL DIALYSIS</b>		
<b>Renal dialysis</b>	<b>20%</b> of the cost	<b>20%</b> of the cost
<b>Kidney disease education services</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>TELEHEALTH SERVICES (in addition to Original Medicare)</b>		
<b>Primary care provider (PCP)</b>	<b>\$0</b> copay	Not Covered
<b>Specialist</b>	<b>\$0</b> copay	Not Covered
<b>Urgent care services</b>	<b>\$0</b> copay	Not Covered
<b>Substance abuse or behavioral health services</b>	<b>\$0</b> copay	Not Covered

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# Covered Medical and Hospital Benefits

## FITNESS AND WELLNESS

SilverSneakers® Fitness Program - Basic fitness center membership including fitness classes.

## 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.

Members are also eligible for nutritious meals delivered to their door at no cost after a diagnosis of COVID-19.

## 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.

## This image shows a blank sheet of white paper designed for handwriting practice. It features a series of horizontal lines. At the very top, there is a dashed line. Below it are several solid lines, creating uniform spaces for writing. The lines extend across the entire width of the page.

## This image shows a blank sheet of white paper designed for handwriting practice. It features a series of horizontal lines spaced evenly down the page. At the very top, there is a dashed line, followed by a solid line, and then another dashed line, creating a three-line guide for letter height. The rest of the page consists of continuous solid horizontal lines. There are no margins, text, or other markings on the paper.

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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, 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 **1-888-700-2263** 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.**  
**1-888-700-2263 (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.**

**1-888-700-2263 (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'eh saad bee áká'ánída'áwo'déé nika'adoowoł.

**العربية (Arabic)**

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك



Find out **more**

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You can see your plan's provider directory at **[our.humana.com/ncshp](http://our.humana.com/ncshp)** 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.

**Humana**<sup>®</sup>

[our.humana.com/ncshp](http://our.humana.com/ncshp)

Base Plan PPO 079/487