

2024

# Summary of Benefits

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**Humana Group Medicare Advantage PPO Plan  
PPO 079/307**

**Hawaii Employer-Union Health Benefits Trust Fund**

**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".

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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



## **A healthy partnership**

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

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## **How to reach us:**

Members should call toll-free **1-888-908-6518** for questions **(TTY/TDD 711)**

Call Monday – Friday, 7 a.m. – 7 p.m.  
Hawaii Standard Time.

Or visit our website:  
**<http://your.humana.com/eutf>**



## 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 your employer group benefits plan administrator.	
<b>Medical deductible</b>	<b>\$100</b> per year for some combined in- and out-of-network services	
<b>Maximum out-of-pocket responsibility</b> The most you pay for copays, coinsurance and other costs for medical services for the year.	<p><b>Combined In and Out-of-Network Maximum Out-of-Pocket \$2,500</b> out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy; Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional) and the Plan Premium do not apply to the combined maximum out-of-pocket.</p> <p>Out-of-Network Exclusions: Part D Pharmacy; Hearing Services (Routine); Worldwide Coverage and the Plan Premium do not apply to the combined maximum out-of-pocket.</p> <p>Your limit for services received from in-network providers will count toward this limit.</p> <p>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.</p>	



## 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>10%</b> of the cost per stay	<b>10%</b> of the cost per stay
<b>OUTPATIENT HOSPITAL COVERAGE</b>		
<b>Outpatient hospital visits</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>Ambulatory surgical center</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>DOCTOR OFFICE VISITS</b>		
<b>Primary care provider (PCP)</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>Specialists</b>	<b>10%</b> of the cost	<b>10%</b> of the cost

**Note:** Some services require prior authorization.



# Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<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>Covered at no cost</b>	<b>Covered at no cost</b>
<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>10%</b> of the cost for Medicare-covered emergency room visit(s)	<b>10%</b> of the cost for Medicare-covered emergency room visit(s)
<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>10%</b> of the cost	<b>10%</b> of the cost
<b>DIAGNOSTIC SERVICES, LABS AND IMAGING</b>		
<b>Diagnostic radiology</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>Lab services</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>Diagnostic tests and procedures</b>	<b>\$0</b> copay or <b>10%</b> of the cost	<b>\$0</b> copay or <b>10%</b> of the cost
<b>Outpatient X-rays</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>Radiation therapy</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>HEARING SERVICES</b>		
<b>Medicare-covered hearing</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>Routine hearing</b>	<b>20%</b> of the cost for hearing aids (all types) up to 1 per ear every 5 years.	<b>20%</b> of the cost for hearing aids (all types) up to 1 per ear every 5 years. Benefits 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>10%</b> 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)	<b>10%</b> 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:** Some services require prior authorization.



# Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>VISION SERVICES</b>		
<b>Medicare-covered vision services</b>	<b>10%</b> of the cost (services include diagnosis and treatment of diseases and injuries of the eye)	<b>10%</b> of the cost (services include diagnosis and treatment of diseases and injuries of the eye)
<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
<b>Medicare-covered eyewear (post-cataract)</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<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>10%</b> of the cost per stay	<b>10%</b> of the cost per stay
<b>Outpatient group and individual therapy visits</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>SKILLED NURSING FACILITY</b>		
Our plan covers up to 120 days in a SNF.  No 3-day hospital stay is required. Plan pays \$0 after 120 days.	<b>\$0</b> copay per day for days 1-20 <b>10%</b> of the cost per stay for days 21-120	<b>\$0</b> copay per day for days 1-20 <b>10%</b> of the cost per stay for days 21-120
<b>PHYSICAL THERAPY</b>		
	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>AMBULANCE</b>		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	<b>10%</b> of the cost	<b>10%</b> of the cost

**Note:** Some services require prior authorization.



# Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>PART B PRESCRIPTION DRUGS</b>		
	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>ACUPUNCTURE SERVICES</b>		
<b>Medicare-covered acupuncture visit(s) for chronic low back pain</b>	<b>10%</b> of the cost for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year.	<b>10%</b> of the cost for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements.		
<b>ALLERGY</b>		
<b>Allergy shots &amp; serum</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>CHIROPRACTIC SERVICES</b>		
<b>Medicare-covered chiropractic visit(s)</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>DIABETES MANAGEMENT TRAINING</b>		
	<b>\$0</b> copay	<b>\$0</b> copay
<b>FOOT CARE (PODIATRY)</b>		
<b>Medicare-covered foot care</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>HOME HEALTH CARE</b>		
	<b>\$0</b> copay	<b>\$0</b> copay
<b>MEDICAL EQUIPMENT/SUPPLIES</b>		
<b>Durable medical equipment (like wheelchairs or oxygen)</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>Medical supplies</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>Prosthetics (artificial limbs or braces)</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>Diabetes monitoring supplies</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>OUTPATIENT SUBSTANCE ABUSE</b>		
<b>Outpatient group and individual substance abuse treatment visits</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>REHABILITATION SERVICES</b>		
<b>Occupational and speech therapy</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>Cardiac rehabilitation</b>	<b>10%</b> of the cost	<b>10%</b> of the cost

**Note:** Some services require prior authorization.



## Covered Medical and Hospital Benefits

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Pulmonary rehabilitation</b>	<b>10%</b> of the cost	<b>10%</b> of the cost
<b>RENAL DIALYSIS</b>		
<b>Renal dialysis</b>	<b>10%</b> of the cost	<b>10%</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	Limited to Original Medicare Coverage
<b>Specialist</b>	<b>10%</b> of the cost	Limited to Original Medicare Coverage
<b>Urgent care services</b>	<b>\$0</b> copay	Limited to Original Medicare Coverage
<b>Substance abuse or behavioral health services</b>	<b>\$0</b> copay	Limited to Original Medicare Coverage

**Note:** 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.

Members would be eligible to receive services for a minimum of 4 hours per day up to a maximum of 8 hours per discharge from an inpatient hospitalization or skilled nursing facility stay.

### 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.

Limitations may apply for above services. For more information, please refer to your Evidence of Coverage document.

### 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.







## Important

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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, ethnicity, marital status, religion, or language. 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.

## Multi-Language Insert

### Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-320-1235 (TTY: 711). Someone who speaks English can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-320-1235 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235 (听障专线：711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-320-1235 (聽障專線：711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بخططنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY: 711) 1-877-320-1235. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-320-1235 (TTY: 711) पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-320-1235 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

**Japanese:** 当社の健康保険と処方薬プランに関するご質問にお答えするために、無料の通訳サービスをご用意しています。通訳をご用命になるには、1-877-320-1235 (TTY:711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。



## Find out **more**

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You can see your plan's provider directory at <http://your.humana.com/eutf> 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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**Humana**<sup>®</sup>

<http://your.humana.com/eutf>