2022

Summary of Benefits

Humana Group Medicare Advantage PPO Plan
PPO 079/358

New Mexico Retiree Health Care Authority - Plan II

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".

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.

Plan name:

Humana Group Medicare Advantage PPO plan

How to reach us:

Members should call toll-free **1-866-396-8810** for questions **(TTY/TDD 711)**

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

Or visit our website: **https://our.humana.com/nmrhca/**

Humana Group Medicare Advantage PPO plan has a network of doctors, hospitals, and other providers. 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/union group.	
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 Testing; COVID-19 Treatment; Fitness Program; Health Education Services; Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; 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.	**Combined In and Out-of-Network Maximum Out-of-Pocket** **$2,500** 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; 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; 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: *some services require prior authorization.*

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.	**$200** per admit	**30%** of the cost per stay
OUTPATIENT HOSPITAL COVERAGE		
Outpatient hospital visits	**$0** to **$125** copay or **20%** of the cost	**$30** copay or **30%** of the cost
Ambulatory surgical center	**$75** copay	**30%** of the cost
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$2** copay	**30%** of the cost
Specialists	**$25** copay	**30%** of the cost
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**	**$0** copay or **0%** to **30%** of the cost for Medicare-covered preventive services **30%** of the cost for a supplemental annual physical exam
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.	**$65** copay for Medicare-covered emergency room visit(s)	**$65** copay for Medicare-covered emergency room visit(s)

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
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.	**$2** to **$25** copay	**$10** copay or **30%** of the cost
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic radiology	**$0** to **$100** copay	**30%** of the cost
Lab services	**$0** copay	**30%** of the cost
Diagnostic tests and procedures	**$0** to **$50** copay	**30%** of the cost
Outpatient X-rays	**$2** to **$50** copay	**30%** of the cost
Radiation therapy	**$25** copay	**30%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**$25** copay	**30%** of the cost
Routine hearing	**$0** copay for fitting/evaluation, routine hearing exams up to 1 per year. **$500** combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 every 3 years.	**$0** copay for fitting/evaluation, routine hearing exams up to 1 per year. **$500** combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 every 3 years. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
DENTAL SERVICES		
Medicare-covered dental	**$25** copay	**30%** of the cost
VISION SERVICES		
Medicare-covered vision services	**$25** copay	**30%** of the cost
Medicare-covered diabetic eye exam	**$0** copay	**30%** of the cost
Medicare-covered glaucoma screening	**$0** copay	**30%** of the cost

Note: *some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
Medicare-covered eyewear (post-cataract)	**$25** copay	**30%** of the cost
Routine vision	**$25** copay for routine exam (includes refraction) up to 1 per year.	**$25** 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.
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	**$200** per admit	**30%** of the cost per stay
Outpatient group and individual therapy visits	**$0** to **$50** copay	**30%** of the cost
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	**30%** of the cost per stay for days 1-100
PHYSICAL THERAPY		
	$0 to **$25** copay	**30%** of the cost
AMBULANCE		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	**$50** copay	**$50** copay
PART B PRESCRIPTION DRUGS		
	$0 copay or **20%** of the cost	**20%** to **30%** of the cost

Note: *some services require prior authorization.*

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.	**$25** copay	**30%** of the cost
Routine acupuncture **20** combined In & Out-of-Network visit limit per plan year	**$15** copay	**$15** copay
ALLERGY		
Allergy shots & serum	**$2** to **$25** copay	**30%** of the cost
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	**$20** copay	**30%** of the cost
Routine chiropractic visit(s) **36** combined In & Out-of-Network visit limit per plan year	**$20** copay	**$20** copay
COVID-19		
Testing and Treatment	**$0** copay for testing and treatment services for COVID-19	
DIABETES MANAGEMENT TRAINING		
	$0 copay	**30%** of the cost
FOOT CARE (PODIATRY)		
Medicare-covered foot care	**$25** copay	**30%** of the cost
Routine foot care **6** combined In & Out-of-Network visit limit per plan year	**$25** copay	**$25** copay
HOME HEALTH CARE		
	$0 copay	**30%** of the cost

Note: *some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**0%** of the cost	**20%** to **30%** of the cost
Medical supplies	**0%** of the cost	**20%** to **30%** of the cost
Prosthetics (artificial limbs or braces)	**0%** of the cost	**30%** of the cost
Diabetes monitoring supplies	**0%** of the cost	**30%** of the cost
OUTPATIENT SUBSTANCE ABUSE		
Outpatient group and individual substance abuse treatment visits	**$0** to **$50** copay	**30%** of the cost
REHABILITATION SERVICES		
Occupational and speech therapy	**$0** to **$25** copay	**30%** of the cost
Cardiac rehabilitation	**$0** to **$20** copay	**30%** of the cost
Pulmonary rehabilitation	**$0** to **$25** copay	**30%** of the cost
RENAL DIALYSIS		
Renal dialysis	**$0** to **$30** copay	**$0** to **$30** copay
Kidney disease education services	**$0** copay	**30%** of the cost
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered
Specialist	**$25** copay	Not Covered
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered
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

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 **1-866-396-8810** 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. 1-866-396-8810 (TTY: 711)

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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.

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فارسی (Farsi)

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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

Find out **more**

You can see your plan's provider directory at **https://our.humana.com/nmrhca/** 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®

https://our.humana.com/nmrhca/

SB079358EN22

2022

Prescription Drug Summary of Benefits

Humana Group Medicare Advantage Plan
Rx 216

New Mexico Retiree Health Care Authority - Plan II

Humana®

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

Find out more about the Humana Group Medicare Advantage Rx 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".

Deductible

Pharmacy (Part D) deductible This plan does not have a deductible.

Prescription Drug Benefits

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach **$4,430**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

Tier	Standard Retail Pharmacy	Standard Mail Order
30-day supply		
1 (Generic or Preferred Generic)	**$4** copay	**$4** copay
2 (Preferred Brand)	**$20** copay	**$20** copay
3 (Non-Preferred Drug)	**$90** copay	**$90** copay
4 (Specialty Tier)	**$125** copay	**$125** copay
90-day supply		
1 (Generic or Preferred Generic)	**$12** copay	**$0** copay
2 (Preferred Brand)	**$60** copay	**$40** copay
3 (Non-Preferred Drug)	**$270** copay	**$180** copay
4 (Specialty Tier)	N/A	N/A

There may be generic and brand-name drugs, as well as Medicare-covered drugs, in each of the tiers. To identify commonly prescribed drugs in each tier, see the Prescription Drug Guide/Formulary.

ADDITIONAL DRUG COVERAGE

Home Infusion Therapy Drugs

If you take certain types of infusion drugs covered under our Medicare Advantage Prescription Drug plans (MA/PD), you may qualify for this service, which helps you and your doctor manage your care without ongoing hospitalization. In some situations home infusion drugs will be covered based on the tier of the drug at the same cost share amount as listed in the chart above when you have reached a total yearly drug cost of **$4,430**. This service includes coverage for the "Coverage Gap" portion of your plan. Drugs included in this coverage are those that would be used as an alternative to inpatient treatment. Your cost for the medication may be the same as it is before the coverage gap sets in. Your out-of-pocket expenses while using this service apply to your "true out-of-pocket" maximum, which is **$7,050** for 2022.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$4,430**. After you enter the coverage gap, you pay a portion of the plan's cost for covered brand name drugs and covered generic drugs until your costs total **$7,050**, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,050**, you pay the greater of:

- **$3.95** for generic (including brand drugs treated as generic) and a **$9.85** copay for all other drugs, or
- **5%** coinsurance

Notes

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الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

Find out **more**

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You can see your plan's drug formulary at **www.humana.com/medicaredruglist** or call us at the number listed at the beginning of this booklet and we will send you one.

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https://our.humana.com/nmrhca/