2016

Summary of Benefits
Humana Group Medicare Advantage PPO Plan

PPO 079/281 - Base Plan
NC State Health Plan

Humana®

SECTION I – INTRODUCTION TO SUMMARY OF BENEFITS

This booklet gives you 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. To get a complete list of our benefits, please call Humana and ask for the "Evidence of Coverage".

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Humana Group Medicare Advantage PPO Plan**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Humana Group Medicare Advantage PPO** covers and what you pay.

- 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**.

Sections in this booklet

- Things to Know About **Humana Group Medicare Advantage PPO**
- Maximum Out-of-Pocket, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits

This document is available in other formats such as Braille and large print.
This document may be available in a non-English language. For additional information, call customer service at the phone number listed below.

Es posible que este documento esté disponible en otros idiomas aparte de inglés. Para obtener información adicional, llame al Servicio al Cliente al número de teléfono que se indica a continuación.

Things to Know About Humana Group Medicare Advantage PPO

Hours of Operation

- Group Medicare Customer Care Hours are Monday - Friday 8:00 a.m. to 9:00 p.m. Eastern time.

Humana Group Medicare Advantage PPO Phone Numbers and Website

- Members should call toll-free **1-800-944-9442** for questions (TTY/TDD **711**)
- Our website: **www.humana.com/ncshp**

Who can join?

To join **Humana Group Medicare Advantage PPO**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and eligible to be covered by NC State Health Plan for Teachers and State Employees.

This plan is available in the following states or municipalities: **Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin,** and **Wyoming**.

The employer, union or trust determines where they are going to offer the plan.

Which doctors and hospitals can I use?

Humana Group Medicare Advantage PPO has a network of doctors, hospitals, and other providers. You can go to doctors, specialists, or hospitals in or out of network as long as they accept Medicare and agree to Humana's payment terms. For more information, please call Group Medicare Customer Care.

You can access a list of covered providers by using **www.humana.com/ncshp** or calling Group Medicare Customer Care.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*.

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact the Humana Group Medicare Advantage PPO Plan for more details.

- **Some Antigens**: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- **Osteoporosis Drugs:** Injectable osteoporosis drugs for some women.
- **Erythropoietin:** By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- **Hemophilia Clotting Factors:** Self-administered clotting factors if you have hemophilia.
- **Injectable Drugs:** Most injectable drugs administered incident to a physician's service.
- **Immunosuppressive Drugs:** Immunosuppressive drug therapy for transplant patients if the transplant took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer for Medicare Part A coverage.
- **Some Oral Cancer Drugs:** If the same drug is available in injectable form.
- **Oral Anti-Nausea Drugs:** If you are part of an anti-cancer chemotherapeutic regimen.
- **Inhalation and Infusion Drugs administered through Durable Medical Equipment.**

SECTION II – SUMMARY OF BENEFITS

Maximum Out of Pocket and Limits on How Much You Pay for Covered Services

Is there a maximum out-of-pocket for my covered services?

Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.

Your yearly limit(s) in this plan:

In-Network Maximum Out-of-Pocket

- **$4,000** out-of-pocket limit for Medicare-covered services. Part D Pharmacy, Fitness Program ; Health Education Services ; Nursing Hotline ; Nutritional Benefit ; Smoking Cessation (Additional) and the Plan Premium do not apply to the maximum out-of-pocket.

If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.

Combined In and Out-of-Network Maximum Out-of-Pocket

- **$4,000** out-of-pocket limit for Medicare-covered services.
- In-Network Exclusions: Part D Pharmacy, Fitness Program ; Health Education Services ; Nursing Hotline ; Nutritional Benefit ; Smoking Cessation (Additional) and the Plan Premium do not apply to the combined maximum out-of-pocket.
- Out-of-Network Exclusions: Part D Pharmacy, 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, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.

Covered Medical and Hospital Benefits

OUTPATIENT CARE AND SERVICES

Ambulance

Medically necessary ambulance services

- In-network: **$75** copayment for Medicare-covered ambulance benefits
- Out-of-network: **$75** copayment for Medicare-covered ambulance benefits

Chiropractic Care

Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):

Medicare-covered chiropractic visit(s)

- In-network: **$20** copayment
- Out-of-network: **$20** copayment

Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: **$40** copayment • Out-of-network: **$40** copayment
Diabetes Supplies and Services	Diabetes monitoring supplies: • In-network: **20%** of the cost • Out-of-network: **20%** of the cost Diabetes self-management training: • In-network: **0%** of the cost • Out-of-network: **0%** of the cost • $50 maximum out-of-pocket per prescription for diabetic medical supplies
Diagnostic Tests, Lab and Radiology Services, and X-Rays	Diagnostic radiology services (such as MRIs, CT scans): • In-network: **$20** to **$125** copayment • Out-of-network: **$20** to **$125** copayment Diagnostic tests and procedures: • In-network: **$20** to **$100** copayment or **0%** of the cost • Out-of-network: **$20** to **$100** copayment or **0%** of the cost Lab services: • In-network: **$40** copayment or **0%** of the cost • Out-of-network: **$40** copayment or **0%** of the cost Outpatient x-rays: • In-network: **$20** to **$100** copayment • Out-of-network: **$20** to **$100** copayment Therapeutic radiology services (such as radiation treatment for cancer): • In-network: **$40** to **$125** copayment • Out-of-network: **$40** to **$125** copayment
Doctor's Office Visits	Primary care physician visit: • In-network: **$20** copayment • Out-of-network: **$20** copayment Specialist visit: • In-network: **$40** copayment • Out-of-network: **$40** copayment Allergy injections and serum: • In-network: **$20** to **$40** copayment • Out-of-network: **$20** to **$40** copayment
Durable Medical Equipment *(wheel chairs, oxygen, etc.)*	• In-network: **20%** of the cost • Out-of-network: **20%** of the cost
Emergency Care	• **$65** copayment for Medicare-covered emergency room visit(s)

	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. Worldwide coverage.
Foot Care *(podiatry services)*	Foot care, including appliances, devices, or shoes for correction or relief of minor ailments and diabetes-related nerve damage and certain conditions: Medicare-covered podiatry visit(s) • In-network: **$40** copayment • Out-of-network: **$40** copayment
Hearing Services	Exam to diagnose and treat hearing and balance issues: • In-network: **$40** copayment • Out-of-network: **$40** copayment Routine hearing: • In-network: **$0 copayment for fitting/evaluation, routine hearing test up to 1 per year.** • Out-of-network: **$0 copayment for fitting/evaluation, routine hearing test up to 1 per year.**
Home Health Care	• In-network: **0%** of the cost • Out-of-network: **0%** of the cost
Mental Health Care	Inpatient visit: 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. • In-network: **$140** copay for days 1-10 • Out-of-network: **$140** copay for days 1-10 • 190 day lifetime limit in a psychiatric facility Outpatient therapy visit: • In-network: **$20** to **$125** copayment • Out-of-network: **$20** to **$125** copayment
Outpatient Rehabilitation	Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered: Medicare-covered therapies: • In-network: **$20** to **$40** copayment • Out-of-network: **$20** to **$40** copayment

	Cardiac (heart) rehabilitation services: • In-network: **$20** to **$40** copayment • Out-of-network: **$20** to **$40** copayment Pulmonary rehabilitation services: • In-network: **$20** to **$40** copayment • Out-of-network: **$20** to **$40** copayment
Outpatient Substance Abuse	Outpatient substance abuse treatment visit: • In-network: **$20** to **$125** copayment • Out-of-network: **$20** to **$125** copayment
Outpatient Services	Ambulatory surgical center: • In-network: **$250** copayment • Out-of-network: **$250** copayment Outpatient hospital visits: • In-network: **$20** to **$250** copayment or **0%** to **20%** of the cost • Out-of-network: **$20** to **$250** copayment or **0%** to **20%** of the cost
Part B Prescription Drugs	• In-network: **0%** to **20%** of the cost • Out-of-network: **0%** to **20%** of the cost • $50 maximum out-of-pocket per prescription for Part B Prescription Drugs
Prosthetic Devices *(braces, artificial limbs, etc.)*	Prosthetic devices: • In-network: **20%** of the cost • Out-of-network: **20%** of the cost Related medical supplies: • In-network: **20%** of the cost • Out-of-network: **20%** of the cost
Private Duty Nursing	• In-network: **4%** of the cost • Out-of-network: **4%** of the cost • $25,000 combined maximum benefit for Private Duty Nursing
Renal Dialysis	Renal dialysis: • In-network: **20%** of the cost • Out-of-network: **20%** of the cost Kidney disease education services: • In-network: **0%** of the cost • Out-of-network: **0%** of the cost
Urgent Care	• In-network: **$20** to **$50** copayment • Out-of-network: **$20** to **$50** copayment
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: **$40** copayment or **0%** of the cost • Out-of-network: **$40** copayment or **0%** of the cost

	Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery: • In-network: **0%** of the cost • Out-of-network: **0%** of the cost Routine vision: • In-network: **$40 copayment for Routine Exam up to 1 per year.** • Out-of-network: **$40 copayment for Routine Exam up to 1 per year.**
PREVENTIVE CARE	• In-network: $0 copayment • Out-of-network: $0 copayment Our plan covers many preventive services, 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 • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Lung cancer 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) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
HOSPICE	• You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.
INPATIENT CARE	
Inpatient Hospital Care	• In-network: **$160** copay for days 1-10 • Out-of-network: **$160** copay for days 1-10

	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.
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)	Our plan covers up to 100 days in a SNF. No 3-day hospital stay is required. • In-network: **$0** copay for days 1-20 **$50** copay for days 21-100 • Out-of-network: **$0** copay for days 1-20 **$50** copay for days 21-100 • Plan pays $0 after 100 days per benefit period

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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 1-800-944-9442. Someone who speaks English/Language 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 1-800-944-9442. 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 1-800-944-9442。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 1-800-944-9442。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 1-800-944-9442. 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 1-800-944-9442. 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 quí vị cần thông dịch viên xin gọi 1-800-944-9442 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-944-9442. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-944-9442 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 1-800-944-9442. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:
إننا نقدم خدمات الترجمة الفورية المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الإتصال بنا على 1-800-944-9442. سيقوم شخص ما يتحدث اللغة العربية بمساعدتك. هذه الخدمة 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 1-800-944-9442 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 1-800-944-9442. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: 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 1-800-944-9442. 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 1-800-944-9442. 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 1-800-944-9442. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 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がありますございます。通訳をご用命になるには、1-800-944-9442にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

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Humana is a Medicare Advantage organization with a Medicare contract. You must continue to pay your Medicare Part B premiums. This is an advertisement. The benefit information provided is a brief summary, not a comprehensive description of benefits. For more information contact the plan. Limitations, copayments and restrictions may apply. Benefits, premium and/or copayments/coinsurance may change each year.

Humana®

www.humana.com/ncshp

Y0040_GHHHM8AHH16

(Pending CMS Approval) PPO 079/281