

# Summary of Benefits

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## **HumanaChoice SNP-DE H5216-164 (PPO D-SNP)**

Missouri

Select Counties in Missouri

**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.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

### Understanding Important Rules

- ☐ 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.
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. This plan may enroll dual eligibles who are QMB Plus and QMB.

# Summary of Benefits

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## **HumanaChoice SNP-DE H5216-164 (PPO D-SNP)**

Missouri

Select Counties in Missouri

**Humana<sup>®</sup>**

Our service area includes the following county/counties in Missouri: Adair, Audrain, Bates, Benton, Bollinger, Boone, Caldwell, Callaway, Camden, Carroll, Carter, Cole, Cooper, Daviess, DeKalb, Franklin, Gasconade, Gentry, Grundy, Henry, Hickory, Howard, Lincoln, Livingston, Macon, Maries, Miller, Mississippi, Moniteau, Monroe, Montgomery, Morgan, Oregon, Osage, Ozark, Pettis, Phelps, Ray, Reynolds, Saline, Schuyler, Scotland, Shelby, St. Clair, Ste. Genevieve, Stoddard, Sullivan, Texas, Vernon.



# Let's talk about HumanaChoice SNP-DE H5216-164 (PPO D-SNP)

Find out more about the HumanaChoice SNP-DE H5216-164 (PPO D-SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice SNP-DE H5216-164 (PPO D-SNP) is a Coordinated Care plan with a Medicare contract and a contract with the MO HealthNet (Medicaid). 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".

As a member, it's a good idea to select a doctor as your Primary Care Provider(PCP). HumanaChoice SNP-DE H5216-164 (PPO D-SNP) has a network of doctors, hospitals, pharmacies and other providers. You have access to Care Managers. Care Managers are nurses or care coordinators who support your health and well-being by providing additional services including: acute and chronic-care management, telephonic and in-person health support, assistance in coordinating Medicare and Medicaid benefits, educational resources and workshops and support for families and caregivers.

## To be eligible

To enroll in HumanaChoice SNP-DE H5216-164 (PPO D-SNP), a Dual Eligible Special Needs Plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B, live in our service area and also receive certain levels of assistance from the MO HealthNet (Medicaid). If you receive both Medicare and Medicaid benefits, this means you are a dual eligible.

HumanaChoice SNP-DE H5216-164 (PPO D-SNP) may enroll dual eligibles who are QMB Plus and QMB.

## Plan name:

HumanaChoice SNP-DE H5216-164 (PPO D-SNP)

## More about HumanaChoice SNP-DE H5216-164 (PPO D-SNP)

As a member of this plan, you will not be responsible for cost sharing for plan benefits. The Comprehensive Benefit Chart shows the benefits you will receive from Humana and how Medicaid covers your cost sharing for those plan benefits. The chart also lists some benefits you could receive from Medicaid if you are eligible for full Medicaid benefits. If you are entitled to Medicaid benefits your care coordinator will work with you to assist you in understanding and accessing the Medicare and Medicaid benefits you may be entitled to.

Be sure to show the MO HealthNet (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.

## How to reach us:

If you have questions about your benefits or your level of eligibility for assistance from Medicaid, you should contact Humana's Customer Care department or the MO HealthNet (Medicaid) for further details.

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](http://Humana.com/medicare)**.

For the most current Missouri Medicaid coverage information, please visit the MO HealthNet (Medicaid) website at

**<http://www.dss.mo.gov/mhd/>** or call the Medicaid Hotline at 1-800-392-2161 (TTY: 711).



## A healthy partnership

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



## Monthly Premium, Deductible and Limits

<b>Monthly plan premium</b>	<b>\$0</b> You must keep paying your Medicare Part B premium. The Part B premium may be covered through the Missouri Medicaid Program.
<b>Medical deductible</b>	This plan does not have a deductible.
<b>Pharmacy (Part D) deductible</b>	This plan does not have a deductible.
<b>Maximum out-of-pocket responsibility</b>	This plan does not have a maximum out-of-pocket responsibility.



## Covered Medical and Hospital Benefits

**MO HealthNet (Medicaid) will pay the cost sharing (deductible, coinsurance and copays) for Original Medicare-covered services for Qualified Medicare Beneficiary (QMB) participants only. You may be required to pay a small Medicaid copay.**

	<b>WHAT YOU PAY ON THIS HUMANA PLAN IN AND OUT-OF-NETWORK</b>	<b>MEDICAID USUAL LIMITS AND COPAYS</b>
<b>ACUTE INPATIENT HOSPITAL CARE</b>		
	<b>\$0</b> copay	<b>\$10</b> copay
<b>OUTPATIENT HOSPITAL COVERAGE</b>		
<b>Outpatient surgery at outpatient hospital</b>	<b>\$0</b> copay	<b>\$3.00</b>
<b>Outpatient surgery at ambulatory surgical center</b>	<b>\$0</b> copay	
<b>DOCTOR OFFICE VISITS</b>		
<b>Primary care provider (PCP)</b>	<b>\$0</b> copay	<b>\$1.00</b>
<b>Specialists</b>	<b>\$0</b> copay	<b>\$1.00</b>
<b>PREVENTIVE CARE</b>		
	<b>Our plan covers many preventive services at no cost including:</b> <ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening</li> <li>• Alcohol misuse counseling</li> <li>• Bone mass measurement</li> <li>• Breast cancer screening (mammogram)</li> <li>• Cardiovascular disease (behavioral therapy)</li> <li>• Cardiovascular screenings</li> </ul>	<b>\$1.00</b>

*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.)

H5216164000

### WHAT YOU PAY ON THIS HUMANA PLAN IN AND OUT-OF-NETWORK

### MEDICAID USUAL LIMITS AND COPAYS

- 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

Any additional preventive services approved by Medicare during the contract year will be covered.

### EMERGENCY CARE

#### Emergency room

**\$0** copay

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.

*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.)

	WHAT YOU PAY ON THIS HUMANA PLAN IN AND OUT-OF-NETWORK	MEDICAID USUAL LIMITS AND COPAYS
<b>Urgently needed services</b> Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	<b>\$0</b> copay	
<b>DIAGNOSTIC SERVICES, LABS AND IMAGING</b>		
<b>Diagnostic mammography</b>	<b>\$0</b> copay	<b>\$1.00</b>
<b>Diagnostic radiology</b>	<b>\$0</b> copay	<b>\$1.00</b>
<b>Lab services</b>	<b>\$0</b> copay	<b>\$1.00</b>
<b>Diagnostic tests and procedures</b>	<b>\$0</b> copay	
<b>Outpatient X-rays</b>	<b>\$0</b> copay	<b>\$1.00</b>
<b>Radiation therapy</b>	<b>\$0</b> copay	
<b>HEARING SERVICES</b>		
<b>Medicare-covered hearing</b>	<b>\$0</b> copay	
<b>Routine hearing</b>	<p>In-network: <b>HER953</b></p> <ul style="list-style-type: none"> <li>• <b>\$0</b> copayment for routine hearing exams up to 1 per year.</li> <li>• <b>\$0</b> copayment for each Advanced level hearing aid up to 1 per ear every 3 years.</li> </ul> <p>Out-of-network: <b>HER953</b></p> <ul style="list-style-type: none"> <li>• <b>\$0</b> copayment for routine hearing exams up to 1 per year.</li> <li>• <b>\$0</b> copayment for each Advanced level hearing aid up to 1 per ear every 3 years.</li> </ul> <p>Hearing aid purchase includes:</p> <ul style="list-style-type: none"> <li>• Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase</li> <li>• 60-day trial period</li> <li>• 3-year extended warranty</li> </ul>	

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.)

### WHAT YOU PAY ON THIS HUMANA PLAN IN AND OUT-OF-NETWORK

### MEDICAID USUAL LIMITS AND COPAYS

- 80 batteries per aid for non-rechargeable models  
**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

**\$0** copay

**\$.50 - \$3.00**

#### Routine dental

In-network:  
**DEN183**

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.

- **\$0** copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.
- **\$0** copayment for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.
- **\$0** copayment for complete dentures, partial dentures up to 1 set(s) every 5 years.
- **\$0** copayment for panoramic film or diagnostic x-rays, recementation up to 1 every 5 years.
- **\$0** copayment for bitewing x-rays up to 1 set(s) per year.
- **\$0** copayment for adjustments to dentures, denture reline, intraoral x-rays, root canal up to 1 per year.
- **\$0** copayment for amalgam and/or composite filling, crown, emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam and/or emergency diagnostic exam, prophylaxis (cleaning) up to 2 per year.
- **\$0** copayment for periodontal maintenance up to 4 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.)

H5216164000

### WHAT YOU PAY ON THIS HUMANA PLAN IN AND OUT-OF-NETWORK

### MEDICAID USUAL LIMITS AND COPAYS

- **\$0** copayment for necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year.
- **\$2500** combined maximum benefit coverage amount per year for preventive and comprehensive benefits.

Out-of-network:

#### **DEN183**

- **\$0** copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.
- **\$0** copayment for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.
- **\$0** copayment for complete dentures, partial dentures up to 1 set(s) every 5 years.
- **\$0** copayment for panoramic film or diagnostic x-rays, recementation up to 1 every 5 years.
- **\$0** copayment for bitewing x-rays up to 1 set(s) per year.
- **\$0** copayment for adjustments to dentures, denture reline, intraoral x-rays, root canal up to 1 per year.
- **\$0** copayment for amalgam and/or composite filling, crown, emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam and/or emergency diagnostic exam, prophylaxis (cleaning) up to 2 per year.
- **\$0** copayment for periodontal maintenance up to 4 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.)

H5216164000

	WHAT YOU PAY ON THIS HUMANA PLAN IN AND OUT-OF-NETWORK	MEDICAID USUAL LIMITS AND COPAYS
	<ul style="list-style-type: none"> <li>• <b>\$0</b> copayment for necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year.</li> <li>• <b>\$2500</b> combined maximum benefit coverage amount per year for preventive and comprehensive benefits.</li> <li>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.</li> </ul>	
<b>VISION SERVICES</b>		
<b>Medicare-covered vision services</b>	<b>\$0</b> copay	<b>\$.50 - \$3.00</b>
<b>Medicare-covered diabetic eye exam</b>	<b>\$0</b> copay	
<b>Medicare-covered glaucoma screening</b>	<b>\$0</b> copay	
<b>Medicare-covered eyewear (post-cataract)</b>	<b>\$0</b> copay	
<b>Routine vision</b>  Refraction is only covered when billed as part of the routine vision exam.  The provider locator for routine vision can be found at <b>Humana.com</b> > Find a Doctor > select Vision care icon > Vision coverage through Medicare Advantage plans.	In-network: <b>VIS704</b> <ul style="list-style-type: none"> <li>• <b>\$0</b> copayment for routine exam up to 1 per year.</li> <li>• <b>\$40</b> combined maximum benefit coverage amount per year for routine exam.</li> <li>• <b>\$500</b> combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.</li> <li>• Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year.</li> </ul>	

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.)

H5216164000

### WHAT YOU PAY ON THIS HUMANA PLAN IN AND OUT-OF-NETWORK

### MEDICAID USUAL LIMITS AND COPAYS

- Maximum benefit coverage amount is limited to one time use per year.

Out-of-network:

#### **VIS704**

- **\$0** copayment for routine exam up to 1 per year.
- **\$40** combined maximum benefit coverage amount per year for routine exam.
- **\$500** 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

**\$0** copay

#### **Outpatient group and individual therapy visits**

**\$0** copay

**\$2.00**

### SKILLED NURSING FACILITY (SNF)

Your plan covers up to 100 days in a SNF

**\$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.)

	WHAT YOU PAY ON THIS HUMANA PLAN IN AND OUT-OF-NETWORK	MEDICAID USUAL LIMITS AND COPAYS
<b>PHYSICAL THERAPY</b>		
	\$0 copay	
<b>AMBULANCE</b>		
Ambulance	\$0 copay	
<b>TRANSPORTATION</b>		
	<p>\$0 copay for plan approved location up to 48 one-way trip(s) per year. This benefit is not to exceed 50 miles per trip.</p> <p>The member <i>must</i> contact transportation vendor to arrange transportation.</p>	



## Prescription Drug Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN IN AND OUT-OF-NETWORK	MEDICAID USUAL LIMITS AND COPAYS
<b>MEDICARE PART B DRUGS</b>		
Chemotherapy drugs	\$0 copay	
Other Part B drugs	\$0 copay	
<b>PRESCRIPTION DRUGS</b>		
Medicare Part D Drugs	See chart below for plan coverage information for prescription drugs	MORx will pay half of the Medicare Part D copay for dual eligibles

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.

**Deductible** This plan does not have a deductible.

Depending on the level of Extra Help you receive, you'll pay one of the following cost-share amounts each time you fill your drug.

### Pharmacy options

<b>Preferred cost-sharing</b>	<b>Mail order:</b> Humana Pharmacy® <b>Retail:</b> To find the preferred cost-share retail pharmacies near you, go to <b>Humana.com/pharmacyfinder</b>	
<b>Standard cost-sharing</b>	<b>Mail order:</b> Walmart Mail <b>Retail:</b> All other network retail pharmacies	
<b>For generic drugs</b> (including brand drugs treated as generic), either:	<b>30-day supply</b>	<b>90-day supply</b>
	<b>\$0</b> copay; or <b>\$1.35</b> copay; or <b>\$3.95</b> copay; or <b>15%</b> of the cost	<b>\$0</b> copay; or <b>\$1.35</b> copay; or <b>\$3.95</b> copay; or <b>15%</b> of the cost
<b>For all other drugs</b> , either:	<b>\$0</b> copay; or <b>\$4</b> copay; or <b>\$9.85</b> copay; or <b>15%</b> of the cost	<b>\$0</b> copay; or <b>\$4</b> copay; or <b>\$9.85</b> copay; or <b>15%</b> of the cost

Other pharmacies are available in our network.

Specialty drugs are limited to a 30-day supply.

Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 Monday — Friday, 7 a.m. — 7 p.m. TTY users should call 1-800-325-0778. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access your "Evidence of Coverage" online.

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

You may get drugs from an out-of-network pharmacy but may pay more than you pay at an in-network pharmacy.

### Days' Supply Available

Unless otherwise specified, you can get your Part D drug in the following days' supply amounts:

- One-month supply (up to 30 days)\*
- Two-month supply (31-60 days)
- Three-month supply (61-90 days)

\*Long term care pharmacy (one-month supply = 31 days)

### 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 nothing for all drugs.



## Additional Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN IN AND OUT-OF-NETWORK	MEDICAID USUAL LIMITS AND COPAYS
Medicare-covered foot care (podiatry)	\$0 copay	\$ .50 - \$3.00
Medicare-covered chiropractic services	\$0 copay	
<b>MEDICAL EQUIPMENT/SUPPLIES</b>		
Durable medical equipment (like wheelchairs or oxygen)	\$0 copay	
Medical Supplies	\$0 copay	
Prosthetics (artificial limbs or braces)	\$0 copay	
Diabetic monitoring supplies	\$0 copay	
<b>REHABILITATION SERVICES</b>		
Occupational and speech therapy	\$0 copay	
Cardiac rehabilitation	\$0 copay	
Pulmonary rehabilitation	\$0 copay	
<b>TELEHEALTH SERVICES (in addition to Original Medicare)</b>		
Primary care provider (PCP)	\$0 copay	
Specialist	\$0 copay	
Urgent care services	\$0 copay	
Substance abuse or behavioral health services	\$0 copay	



## Additional Medicaid Covered Services

Dual eligible members who meet financial criteria for full Medicaid coverage may also be eligible to receive all Medicaid services not covered by Medicare. HumanaChoice SNP-DE H5216-164 (PPO D-SNP) may also offer coverage for these services. The benefits described in the Covered Medical and Hospital Benefits section of the Summary of Benefits are covered by Medicare. The benefits described below are covered by Medicaid. For each benefit listed below, you can see what the MO HealthNet (Medicaid) covers and what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility. If you have questions about your Medicaid eligibility and what benefits you are entitled to call the MO HealthNet (Medicaid): 1-800-392-2161 (TTY: 711).

BENEFIT	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID STATE PLAN
<b>PRODUCTS AND DEVICES</b>		
<b>Dentures</b>	See “Dental” benefit in the “Covered Medical and Hospital Benefits” chart above	Covered services and cost sharing requirements for the MO HealthNet (Missouri Medicaid) Program can be found at <a href="http://dss.mo.gov/mhd/general/pages/about.htm">http://dss.mo.gov/mhd/general/pages/about.htm</a>
<b>Eyeglasses</b>	See “Vision” benefit in the “Covered Medical and Hospital Benefits” chart above	Covered services and cost sharing requirements for the MO HealthNet (Missouri Medicaid) Program can be found at <a href="http://dss.mo.gov/mhd/general/pages/about.htm">http://dss.mo.gov/mhd/general/pages/about.htm</a>
<b>Hearing Aids</b>	See “Hearing” benefit in the “Covered Medical and Hospital Benefits” chart above	Covered services and cost sharing requirements for the MO HealthNet (Missouri Medicaid) Program can be found at <a href="http://dss.mo.gov/mhd/general/pages/about.htm">http://dss.mo.gov/mhd/general/pages/about.htm</a>
<b>TRANSPORTATION</b>		
<b>Non-Emergency Medical Transportation Services</b>	See “Transportation” benefit in the “Covered Medical and Hospital Benefits” chart above	Covered services and cost sharing requirements for the MO HealthNet (Missouri Medicaid) Program can be found at <a href="http://dss.mo.gov/mhd/general/pages/about.htm">http://dss.mo.gov/mhd/general/pages/about.htm</a>
<b>INPATIENT LONG TERM CARE SERVICES</b>		
<b>Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services in Institutions for Mental Diseases (IMD), age 65 and older</b>	Not covered	Covered services and cost sharing requirements for the MO HealthNet (Missouri Medicaid) Program can be found at <a href="http://dss.mo.gov/mhd/general/pages/about.htm">http://dss.mo.gov/mhd/general/pages/about.htm</a>
<b>Inpatient Psychiatric Services, under age 21</b>	See “Mental Health” benefit in the “Covered Medical and Hospital Benefits” chart above	Covered services and cost sharing requirements for the MO HealthNet (Missouri Medicaid) Program can be found at <a href="http://dss.mo.gov/mhd/general/pages/about.htm">http://dss.mo.gov/mhd/general/pages/about.htm</a>



<b>Intermediate Care Facility Services for Individuals with Intellectual Disabilities</b>	Not Covered	Covered services and cost sharing requirements for the MO HealthNet (Missouri Medicaid) Program can be found at <a href="http://dss.mo.gov/mhd/general/pages/about.htm">http://dss.mo.gov/mhd/general/pages/about.htm</a>
<b>Nursing Facility Services, other than in an Institution for Mental Diseases</b>	See “Skilled Nursing” benefit in the “Covered Medical and Hospital Benefits” chart above	Covered services and cost sharing requirements for the MO HealthNet (Missouri Medicaid) Program can be found at <a href="http://dss.mo.gov/mhd/general/pages/about.htm">http://dss.mo.gov/mhd/general/pages/about.htm</a>

### HOME AND COMMUNITY BASED WAIVER SERVICES

Dual eligible members, who meet the financial criteria for full Medicaid coverage, may also be eligible to receive Waiver services. Waiver services are limited to individuals who meet additional waiver eligibility criteria. For information on waiver services and eligibility, contact the MO HealthNet (Medicaid) at 1-800-392-2161 (TTY: 711).

**\*\*Exemptions.** The following categories of recipients are not required to pay a copayment or coinsurance:

- (a) Recipients under 19 years of age or ME codes 06, 33, 34, 36, 40, 52, 56, 57, 60, 62, 64, 65, 71, 72, 73, 74, 75, 87, 88, and 97;
- (b) Institutionalized recipients residing in a skilled nursing facility, intermediate care, nursing home,
- (c) Services to recipients who have both Medicare and Medicaid if Medicare covers the service and
- (d) Emergency admissions or transfer inpatient admissions
- (e) Emergency services provided in an outpatient clinic or emergency room after the sudden onset of (including severe pain ) that the absence of immediate medical attention could reasonably be
- (f) Placing the patient's health in serious jeopardy;
- (g) Serious impairment to bodily functions; or
- (h) Serious dysfunction of any bodily organ or part;
- (i) Certain therapies - chronic renal dialysis, physical, radiation, and chemotherapy,
- (j) Pregnant women with ME codes: 18, 43, 44, 45, 58, 59, 61, 94, 95, 96, and 98
- (k) Foster children with ME codes: 07, 08, 28, 29, 30, 37, 49, 50, 51, 66, 67, 68, 69, and 70;
- (l) Services identified as medically necessary through an Early Periodic Screening;
- (m) Blind individuals with ME codes: 02, 03, 12 and 15;
- (n) Managed Care enrollees;
- (o) Mental Health services provided by Dept. of Mental Health operated Community Mental Health Centers (CMHC) or designated by DMH as a CMHC, or as an drug treatment facility, or as a child-serving agency within the comprehensive children's mental health service system;
- (p) Family Planning Services;
- (q) Hospice Services;
- (r) Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his physician or an outpatient, rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility.
- (s) NEMT public transit and gas reimbursement modes of transportation;

The Additional Medicaid Covered Services table above reflects services available on a fee for service basis for dual eligibles who meet the eligibility requirements for full Medicaid benefits.

The Medicaid information included in this section is current as of 7/1/2020. All Medicaid covered services are subject to change at any time. For the most current Missouri Medicaid coverage information, please visit the MO HealthNet (Medicaid) website at <http://www.dss.mo.gov/mhd/> or call the Medicaid Hotline at 1-800-392-2161 (TTY: 711).



# 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.

## **Healthy Foods Card**

**\$50** automatically loaded every month to spend at participating retailers toward the purchase of healthy foods.

## **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.

## **Special Supplemental Benefits for the Chronically Ill (SSBCI) Humana Flexible Care Assistance**

Humana Flexible Care Assistance is available to chronically ill members who are participating with care management services and meet program criteria. Eligible members may receive medical expenses assistance, primarily health related, and non-primarily health related additional benefits to address specific needs based on the individual's unique situations. Benefits are limited up to **\$500** per year and must be coordinated and authorized by a care manager. There is no cost to participate.

## **Smoking cessation program**

To further assist in your effort to quit smoking or tobacco product use, we cover one additional counseling quit attempt within a 12-month period as a service with no cost to you. This is in addition to the two counseling attempt provided by Medicare and includes up to four face-to-face visits. This service can be used for either preventive measures or for diagnosis with a tobacco related disease.

## **Humana Well Dine® Meal Program**

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

## **Special Supplemental Benefits for the Chronically Ill (SSBCI) Worry Free™ Meals**

Members diagnosed with Chronic Obstructive Pulmonary Disease (COPD), Diabetes, or Congestive Heart Failure (CHF), participating with care management services, and who meet program criteria may receive 2 meals per day for 12 weeks, 168 meals total. Additional 12 weeks of meals may be available as determined by the plan. Members may qualify for the Worry Free™ Meals program up to two times per plan year. There is no cost to participate. Authorization may be required.

**Over-the-Counter (OTC) card**

**\$100** maximum benefit coverage amount per month for over-the-counter (OTC) card to purchase eligible OTC health and wellness products at participating retailers.

**Personal Emergency Response System**

The personal emergency response system provides help in emergency situations. The medical alert service comes with an installed in-home communication device and a wearable button. You have the choice between a push button unit (with or without AutoAlert fall detection) or a wrist unit (without AutoAlert).

**Rewards and Incentives**

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

**Wigs (related to chemotherapy treatment)**

Up to a **\$500** combined in and out of network maximum benefit per year.

**SilverSneakers® fitness program**

Basic fitness center membership including fitness classes.



## Find out **more**

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



You can see our plan's **drug guide** at our website at **[humana.com/medicaredruglist](https://www.humana.com/medicaredruglist)** 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.

Humana has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2023 based on a review of Humana's Model of Care.

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

# 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):** Wóda'í béésh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá jii'eh saad bee áká'ánída'áwo'déé nika'adoowoł.

**العربية (Arabic)**

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك



HumanaChoice SNP-DE H5216-164  
(PPO D-SNP)

H5216164000 ENG

Select Counties in Missouri

