2022

Summary of Benefits

HumanaChoice SNP-DE H5216-291 (PPO D-SNP)

Maine

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, QMB, SLMB Plus and FBDE.

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Our service area includes the following county/counties in Maine: Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, Washington, York.

Let's talk about HumanaChoice SNP-DE H5216-291 (PPO D-SNP)

Find out more about the HumanaChoice SNP-DE H5216-291 (PPO D-SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice SNP-DE H5216-291 (PPO D-SNP) is a Coordinated Care plan with a Medicare contract and a contract with the Maine Department of Health and Human Services (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 H5216-291 (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 H5216-291 (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 Maine Department of Health and Human Services (Medicaid). If you receive both Medicare and Medicaid benefits, this means you are a dual eligible.

HumanaChoice SNP-DE H5216-291 (PPO D-SNP) may enroll dual eligibles who are QMB Plus, QMB, SLMB Plus and FBDE.

Plan name:

HumanaChoice SNP-DE H5216-291 (PPO D-SNP)

More about HumanaChoice SNP-DE H5216-291 (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 Maine Department of Health and Human Services (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 Maine Department of Health and Human Services (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**.

For the most current Maine Medicaid coverage information, please visit the Maine Department of Health and Human Services (Medicaid) website at **http://www.maine.gov/dhhs/oms/member/member_index.html** or call the Medicaid Hotline at 1-800-977-6740 (TTY: 711).

A healthy partnership

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

Monthly Premium, Deductible and Limits

Monthly plan premium	**$0** You must keep paying your Medicare Part B premium. The Part B premium may be covered through the Maine Medicaid Program.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	**$0** if you qualify for Extra Help
Maximum out-of-pocket responsibility	This plan does not have a maximum out-of-pocket responsibility.

Covered Medical and Hospital Benefits

For members protected by the Maine Department of Health and Human Services (Medicaid) Program from cost sharing, Medicaid pays coinsurance, copays, and deductibles for Original Medicare-covered services as long as the provider accepts Maine Department of Health and Human Services (Medicaid). You may be required to pay a small Medicaid copay.

	WHAT YOU PAY ON THIS HUMANA PLAN IN AND OUT-OF-NETWORK	MEDICAID USUAL LIMITS AND COPAYS
ACUTE INPATIENT HOSPITAL CARE		
	$0 copay	The amount of copay shall not exceed **$3.00** per day for services provided, according to the following schedule.** Service Amount: Member Copay: $10.00 or less **$0.50** $10.01 - 25.00 **$1.00** $25.01 - 50.00 **$2.00** $50.01 or more **$3.00**
OUTPATIENT HOSPITAL COVERAGE		
Outpatient surgery at outpatient hospital	**$0** copay	The amount of copay shall not exceed **$3.00** per day for services provided, according to the following schedule.** Service Amount: Member Copay: $10.00 or less **$0.50** $10.01 - 25.00 **$1.00** $25.01 - 50.00 **$2.00** $50.01 or more **$3.00**

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
Outpatient surgery at ambulatory surgical center	**$0** copay	The amount of copay shall not exceed **$3.00** per day for services provided, according to the following schedule.** Service Amount: Member Copay: $10.00 or less **$0.50** $10.01 - 25.00 **$1.00** $25.01 - 50.00 **$2.00** $50.01 or more **$3.00**
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**$0** copay
Specialists	**$0** copay	**$0** copay
PREVENTIVE CARE		
	Our plan covers many preventive services at no cost 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 • 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)	

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	WHAT YOU PAY ON THIS HUMANA PLAN IN AND OUT-OF-NETWORK	MEDICAID USUAL LIMITS AND COPAYS
	• 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 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.	**$0** copay	
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$0** copay	
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic mammography	**$0** copay	The amount of copay shall not exceed **$1.00** per day for services provided, according to the following schedule.** Service Amount: Member Copay: $10.00 or less **$0.50** $10.01 or more **$1.00**

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
Diagnostic radiology	**$0** copay	The amount of copay shall not exceed **$1.00** per day for services provided, according to the following schedule.** Service Amount: Member Copay: $10.00 or less **$0.50** $10.01 or more **$1.00**
Lab services	**$0** copay	The amount of copay shall not exceed **$1.00** per day for services provided, according to the following schedule.** Service Amount: Member Copay: $10.00 or less **$0.50** $10.01 or more **$1.00**
Diagnostic tests and procedures	**$0** copay	The amount of copay shall not exceed **$1.00** per day for services provided, according to the following schedule.** Service Amount: Member Copay: $10.00 or less **$0.50** $10.01 or more **$1.00**
Outpatient X-rays	**$0** copay	The amount of copay shall not exceed **$1.00** per day for services provided, according to the following schedule.** Service Amount: Member Copay: $10.00 or less **$0.50** $10.01 or more **$1.00**
Radiation therapy	**$0** copay	The amount of copay shall not exceed **$1.00** per day for services provided, according to the following schedule.** Service Amount: Member Copay: $10.00 or less **$0.50** $10.01 or more **$1.00**
HEARING SERVICES		
Medicare-covered hearing	**$0** copay	

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Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN IN AND OUT-OF-NETWORK	MEDICAID USUAL LIMITS AND COPAYS
Routine hearing	In-network: **HER953** • **$0** copayment for routine hearing exams up to 1 per year. • **$0** copayment for each Advanced level hearing aid up to 1 per ear every 3 years. Out-of-network: **HER953** • **$0** copayment for routine hearing exams up to 1 per year. • **$0** copayment for each Advanced level hearing aid up to 1 per ear every 3 years. Hearing aid purchase includes: • Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase • 60-day trial period • 3-year extended warranty • 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	• Covered for children • Coverage for members over age twenty-one (21) is limited to oral surgeries unrelated to dentition and gingiva, acute surgery following trauma, extraction of severely decayed teeth, treatment necessary to relieve pain, eliminate infection or prevent tooth loss, or procedures necessary to correct an underlying medical condition
Routine dental 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	In-network: **DEN132** • **$0** copayment for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **$0** copayment for panoramic film or diagnostic x-rays up to 1 every 5 years.	

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.

	WHAT YOU PAY ON THIS HUMANA PLAN IN AND OUT-OF-NETWORK	MEDICAID USUAL LIMITS AND COPAYS
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 bitewing x-rays up to 1 set(s) per year. • **$0** copayment for intraoral x-rays up to 1 per year. • **$0** copayment for amalgam and/or composite filling, periodic oral exam, prophylaxis (cleaning), simple or surgical extraction up to 2 per year. • **$0** copayment for necessary anesthesia with covered service up to unlimited per year. Out-of-network: **DEN132** • **$0** copayment for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **$0** copayment for panoramic film or diagnostic x-rays up to 1 every 5 years. • **$0** copayment for bitewing x-rays up to 1 set(s) per year. • **$0** copayment for intraoral x-rays up to 1 per year. • **$0** copayment for amalgam and/or composite filling, periodic oral exam, prophylaxis (cleaning), simple or surgical extraction up to 2 per year. • **$0** copayment for necessary anesthesia with covered service up to unlimited per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.	

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
VISION SERVICES		
Medicare-covered vision services	**$0** copay	• For members who are under age twenty-one (21) or who reside in an ICF-MR, Maine Department of Health and Human Services (Medicaid) will pay for one annual routine eye exam. • For members ages twenty-one (21) and over, Maine Department of Health and Human Services (Medicaid) will pay for only one routine eye exam every three (3) rolling calendar years, except that routine eye exams indicated as standard of care for specific medical diagnoses (ex. diabetes) or medication use (ex. Plaquenil) will be covered as medically indicated.
Medicare-covered diabetic eye exam	**$0** copay	
Medicare-covered glaucoma screening	**$0** copay	
Medicare-covered eyewear (post-cataract)	**$0** copay	
Routine vision Refraction is only covered when billed as part of the routine vision exam. The provider locator for routine vision can be found at **Humana.com** > Find a Doctor > select Vision care icon > Vision coverage through Medicare Advantage plans.	In-network: **VIS711** • **$0** copayment for routine exam up to 1 per year. • **$40** combined maximum benefit coverage amount per year for routine exam. • **$300** 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. Out-of-network: **VIS711** • **$0** copayment for routine exam up to 1 per year. • **$40** combined maximum benefit coverage amount per year for routine exam. • **$300** combined maximum benefit coverage amount per year for contact lenses or	

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.

	WHAT YOU PAY ON THIS HUMANA PLAN IN AND OUT-OF-NETWORK	MEDICAID USUAL LIMITS AND COPAYS
	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	**$0** copay for members under 21 or over 65 • Not covered for members ages 21 to 64 except that if a member receives inpatient services immediately before he or she reaches age twenty-one (21), the member is eligible for continued service until he or she reaches age twenty-two (22) or the date when service is no longer required, whichever comes first.
Outpatient group and individual therapy visits	**$0** copay	
SKILLED NURSING FACILITY (SNF)		
Your plan covers up to 100 days in a SNF	**$0** copay	**$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
PHYSICAL THERAPY		
	$0 copay	PT and OT services covered with limitations for adults.** Service Amount: Member Copay: $10.00 or less **$0.50** $10.01 - 25.00 **$1.00** $25.01 - 50.00 **$2.00**
AMBULANCE		
Ambulance	**$0** copay	The amount of copay shall not exceed **$3.00** per day for services provided, according to the following schedule.** Service Amount: Member Copay: $10.00 or less **$0.50** $10.01 - 25.00 **$1.00** $25.01 - 50.00 **$2.00** $50.01 or more **$3.00**
TRANSPORTATION		
	$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. The member *must* contact transportation vendor to arrange transportation.	Non-emergency transportation to Maine Department of Health and Human Services (Medicaid) covered services is covered.

Prescription Drug Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN IN AND OUT-OF-NETWORK	MEDICAID USUAL LIMITS AND COPAYS
MEDICARE PART B DRUGS		
Chemotherapy drugs	**$0** copay	
Other Part B drugs	**$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.

PRESCRIPTION DRUGS		
Medicare Part D Drugs	See chart below for plan coverage information for prescription drugs	The amount of the copay shall be three dollars (**$3.00**) per prescription, not to exceed thirty dollars (**$30.00**) per member per month, except for tobacco cessation products and prescriptions filled by the Department's mail order pharmacy providers.** Medicaid may cover some drugs that are not covered by Part D. Contact the Maine Department of Health and Human Services (Medicaid) agency for questions on drug coverage. Medicaid (Maine Department of Health and Human Services) covers some prescription drugs that are specifically "excluded" from Medicare Part D coverage.

Prescription Drug Savings Benefit $0 copayment for all Medicare covered prescription drugs for all formularies, on all tiers. Benefit begins in the Deductible Stage (when applicable) and continues through Initial Coverage Stage, only. Once your total drug costs have reached **$4,430** you pay the cost-shares in the chart below. To qualify, members must be eligible for Extra Help.
Deductible $0 if you qualify for Extra Help.

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		
Preferred cost-sharing	**Mail order:** Humana Pharmacy® **Retail:** To find the preferred cost-share retail pharmacies near you, go to **Humana.com/pharmacyfinder**	
Standard cost-sharing	**Mail order:** Walmart Mail **Retail:** All other network retail pharmacies	
For generic drugs (including brand drugs treated as generic), either:	**30-day supply** **$0** copay; or **$1.35** copay; or **$3.95** copay; or **15%** of the cost	**90-day supply** **$0** copay; or **$1.35** copay; or **$3.95** copay; or **15%** of the cost
For all other drugs, either:	**$0** copay; or **$4** copay; or **$9.85** copay; or **15%** of the cost	**$0** copay; or **$4** copay; or **$9.85** copay; or **15%** 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	Service Amount: Member Copay**: $10.00 or less **$0.50** $10.01 - 25.00 **$1.00** $25.01 or more **$2.00**
Medicare-covered chiropractic services	**$0** copay	Limit on visits for adults (over 21) Service Amount: Member Copay**: $10.00 or less **$0.50** $10.01 - 25.00 **$1.00** $25.01 or more **$2.00**
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**$0** copay	Covered with limitations Service Amount: Member Copay**: $10.00 or less **$0.50** $10.01 - 25.00 **$1.00** $25.01 - 50.00 **$2.00** $50.01 or more **$3.00** • Members shall not be charged more than $3.00 per month for any rental service. • No co-payment may be imposed with respect to all oxygen and oxygen equipment services.
Medical Supplies	**$0** copay	Covered with limitations Service Amount: Member Copay**: $10.00 or less **$0.50** $10.01 - 25.00 **$1.00** $25.01 - 50.00 **$2.00** $50.01 or more **$3.00**
Prosthetics (artificial limbs or braces)	**$0** copay	Covered with limitations Service Amount: Member Copay**: $10.00 or less **$0.50** $10.01 - 25.00 **$1.00** $25.01 - 50.00 **$2.00** $50.01 or more **$3.00**

	WHAT YOU PAY ON THIS HUMANA PLAN IN AND OUT-OF-NETWORK	MEDICAID USUAL LIMITS AND COPAYS
Diabetic monitoring supplies	**$0** copay	Covered with limitations Service Amount: Member Copay**: $10.00 or less **$0.50** $10.01 - 25.00 **$1.00** $25.01 - 50.00 **$2.00** $50.01 or more **$3.00**
REHABILITATION SERVICES		
Occupational and speech therapy	**$0** copay	PT and OT services covered with limitations for adults Service Amount: Member Copay**: $10.00 or less **$0.50** $10.01 - 25.00 **$1.00** $25.01 or more **$2.00**
Cardiac rehabilitation	**$0** copay	
Pulmonary rehabilitation	**$0** copay	
TELEHEALTH SERVICES (in addition to Original Medicare)		
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 H5216-291 (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 Maine Department of Health and Human Services (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 Maine Department of Health and Human Services (Medicaid): 1-800-977-6740 (TTY: 711).

BENEFIT	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID STATE PLAN
PRODUCTS AND DEVICES		
Dentures	See "Dental" benefit in the "Covered Medical and Hospital Benefits" chart above	Full and partial dentures, medically necessary to correct or ameliorate an underlying medical condition, if the Department determines that the provision of those services will be cost-effective in comparison to the provision of other covered medical services for the treatment of that condition.
Eyeglasses	See "Vision" benefit in the "Covered Medical and Hospital Benefits" chart above	For members under age twenty-one (21), Maine Department of Health and Human Services (Medicaid) will pay for eyeglasses when the refractive error in at least one eye meets at least one of the following definitions: • Hyperopia: +1.25 diopter or over • Myopia: -0.75 diopter or over • Astigmatism:-0.50 diopter or over Providers must request and receive prior authorization from the Maine Department of Health and Human Services (Medicaid) Authorization Unit or its authorized agent for cases where the refractive error is below the criteria set forth above. The Prior Authorization Unit or its authorized agent will require written justification of the medical necessity in such cases. For members ages twenty-one (21) and over, Maine Department of Health and Human Services (Medicaid) will pay for one pair of eyeglasses per lifetime when the

		power is equal to or greater than 10.00 diopters. The amount of copays for services provided, according to the following schedule**. Service Amount: Member Copay: $10.00 or less **$ 0.50** $10.01 - 25.00 **$ 1.00** $25.01 - 50.00 **$ 2.00** $50.01 or more **$ 3.00 (or $2.00 if provided by an optician)** Co-payment for members may not exceed $2.00 per day or $20.00 per month for services provided by an optician or $3.00 per day or $30.00 per month for services provided by an optometrist.
Hearing Aids	See "Hearing" benefit in the "Covered Medical and Hospital Benefits" chart above	Covered for adults and children with differing requirements
TRANSPORTATION		
Non-Emergency Medical Transportation Services	See "Transportation" benefit in the "Covered Medical and Hospital Benefits" chart above	Members receive transportation service to and from Maine Department of Health and Human Services (Medicaid) covered services, when the member is unable to provide their own transportation. These are arranged and paid for by a transportation Broker, and provided by various modes of transportation. For travel out of state for medical appointments, the member must have the travel preauthorized by Maine Department of Health and Human Services (Medicaid). In cases where the travel requires overnight stays, meals and lodging are also a covered benefit for Maine Department of Health and Human Services (Medicaid) members.

INPATIENT LONG TERM CARE SERVICES		
Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services in Institutions for Mental Diseases (IMD), age 65 and older	Not covered	The amount of copay shall not exceed **$3.00** per day for services provided, according to the following schedule.** Service Amount: Member Copay: $10.00 or less **$0.50** $10.01 - 25.00 **$1.00** $25.01 - 50.00 **$2.00** $50.01 or more **$3.00**
Inpatient Psychiatric Services, under age 21	See "Mental Health" benefit in the "Covered Medical and Hospital Benefits" chart above	**$0** copay
Intermediate Care Facility Services for Individuals with Intellectual Disabilities	Not Covered	**$0** copay
Nursing Facility Services, other than in an Institution for Mental Diseases	See "Skilled Nursing" benefit in the "Covered Medical and Hospital Benefits" chart above	**$0** copay
OTHER MEDICAID-COVERED SERVICES		
Over-the-Counter (OTC) Benefit	See "Over-the-Counter benefit" in the "More benefits with your plan" section later in this document.	Some over-the-counter drugs are covered when filled by prescription.
Hospice	**You pay nothing** for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	**$0** copay

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 Maine Department of Health and Human Services (Medicaid) at 1-800-609-7893 (TTY: 711).

COMMUNITY BASED LONG TERM CARE SERVICES

Dual eligible members, who meet the financial criteria for full Medicaid coverage, may also be eligible to receive some of the following community based services: Adult Family Care Services, Community Support Services, Day Habilitation Services, Support Benefits for Adults with Intellectual Disabilities or Autistic Disorder.

These services are limited to individuals who meet additional medical eligibility criteria. For information on in-home services and eligibility, contact the Maine Department of Health and Human Services (Medicaid) at 1-800-977-6740 (TTY: 711).

CONSUMER DIRECTED ATTENDANT SERVICES

Dual eligible members, who meet the financial criteria for full Medicaid coverage, may also be eligible for Consumer Directed Attendant Services. These services are limited to individuals who meet additional medical eligibility criteria. For information on Consumer Directed Attendant services and eligibility, contact the Maine Department of Health and Human Services (Medicaid) at 1-800-609-7893.

The amount of copay shall not exceed **$3.00** per day for services provided, according to the following schedule**:

Service Amount:	Member Copay:
$10.00 or less	**$0.50**
$10.01 - 25.00	**$1.00**
$25.01 - 50.00	**$2.00**
$50.01 or more	**$3.00**

Maine Department of Health and Human Services (Medicaid) does not charge copays for any service when the member is under the age of twenty-one (21), the member is pregnant, or the member is in state custody or guardianship.

**Exemptions. No copayment may be imposed with respect to the following services:

A. Family planning services and supplies;
B. Services furnished to members under twenty-one (21) years of age;
C. Services furnished to any individual who is an inpatient in a hospital, skilled nursing facility, nursing facility, ICF/IID, or other medical institution, or a resident of a private non-medical institution, if that individual is determined by the Department to be responsible, as a condition of receiving services in that institution, to have an "assessment" or a "cost of care." Cost of care is defined in the *Maine Department of Health and Human Services (Medicaid) Eligibility Manual* and is not waived or affected by any of these exemptions;
D. Services and drugs furnished to pregnant women, including services and drugs provided during the three months following the end of a pregnancy;
E. Services received under the Limited Family Planning Benefit;
F. Members in State custody;
G. Services provided in Indian Health Service Centers and services for Native American members who are eligible to receive services funded by Contract Health Services;
H. Members under State guardianship
I. Members receiving Hospice Services;
J. Emergency services as defined in Chapter I, Section 1.02.4 (B) of this Manual;
K. Tobacco cessation services and products;
L. Members whose monthly copayment sum has totaled five percent (5%) of their monthly income;
M. Any additional exceptions listed in specific sections of Chapter II of this Manual.

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 7/1/2021. All Medicaid covered services are subject to change at any time. For the most current Maine Medicaid coverage information, please visit the Maine Department of Health and Human Services (Medicaid) website at **http://www.maine.gov/dhhs/oms/member/member_index.html** or call the Medicaid Hotline at 1-800-977-6740 (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.

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.

Over-the-Counter (OTC) card

$75 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).

Personal Home Care

$0 copay for a minimum of 3 hours per day, up to a maximum of 42 hours per year for certain in-home services to assist individuals with disabilities and/or medical conditions in performing activities of daily living (ADLs) within the home by a qualified aide (e.g., assistance with bathing, dressing, toileting, walking, eating, and preparing meals).

Authorization may be required. Contact the plan for details.

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**

You can see our plan's **provider and pharmacy directory** at our website at **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** 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): 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

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