2022

# Summary of Benefits

## HumanaChoice SNP-DE H5525-046 (PPO D-SNP)

Ohio
Select counties in Ohio

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, QMB Plus, SLMB Plus and FBDE.

2022

# Summary of Benefits

## HumanaChoice SNP-DE H5525-046 (PPO D-SNP)

Ohio
Select counties in Ohio

Humana®

Our service area includes the following county/counties in Ohio: Adams, Ashland, Ashtabula, Athens, Auglaize, Belmont, Brown, Champaign, Clinton, Columbiana, Coshocton, Crawford, Darke, Defiance, Fayette, Fulton, Gallia, Guernsey, Hancock, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Knox, Lawrence, Logan, Madison, Marion, Meigs, Mercer, Monroe, Morgan, Morrow, Muskingum, Noble, Paulding, Perry, Pickaway, Pike, Putnam, Richland, Ross, Scioto, Shelby, Tuscarawas, Union, Van Wert, Vinton, Washington, Williams, Wyandot.

# Let's talk about HumanaChoice SNP-DE H5525-046 (PPO D-SNP)

Find out more about the HumanaChoice SNP-DE H5525-046 (PPO D-SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice SNP-DE H5525-046 (PPO D-SNP) is a Coordinated Care plan with a Medicare contract and a contract with the Ohio Department of Medicaid (ODM). 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 H5525-046 (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 H5525-046 (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 Ohio Department of Medicaid (ODM). If you receive both Medicare and Medicaid benefits, this means you are a dual eligible.

HumanaChoice SNP-DE H5525-046 (PPO D-SNP) may enroll dual eligibles who are QMB, QMB Plus, SLMB Plus and FBDE.

## Plan name:

HumanaChoice SNP-DE H5525-046 (PPO D-SNP)

## More about HumanaChoice SNP-DE H5525-046 (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 Ohio Department of Medicaid (ODM) 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 Ohio Department of Medicaid (ODM) 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 Ohio Medicaid coverage information, please visit the Ohio Department of Medicaid (ODM) website at **http://jfs.ohio.gov/ohp/** or call the Medicaid Hotline at 1-800-324-8680 (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**<br>You must keep paying your Medicare Part B premium. The Part B premium may be covered through the Ohio 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 Ohio Department of Medicaid (ODM) Program from cost sharing, Medicaid pays coinsurance, copays and deductibles for Original Medicare-covered services. 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 | **$0** copay<br>• Covered as needed and when medically necessary<br>• Prior approval may be needed for some surgeries<br>• Less than 30 covered days and 60 days after discharge<br>• Chemical dependency detoxification is also covered |
| **OUTPATIENT HOSPITAL COVERAGE** | | |
| **Outpatient surgery at outpatient hospital** | **$0** copay | |
| **Outpatient surgery at ambulatory surgical center** | **$0** copay | |
| **DOCTOR OFFICE VISITS** | | |
| **Primary care provider (PCP)** | **$0** copay | **$0** copay for Medicaid-covered services<br>• Up to 24 visits per year<br>• Additional visits will be authorized if medically necessary |
| **Specialists** | **$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 |
|---|---|---|
| **PREVENTIVE CARE** | | |
| | **Our plan covers many preventive services at no cost including:**<br>• Abdominal aortic aneurysm screening<br>• Alcohol misuse counseling<br>• Bone mass measurement<br>• Breast cancer screening (mammogram)<br>• Cardiovascular disease (behavioral therapy)<br>• Cardiovascular screenings<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)<br>• Depression screening<br>• Diabetes screenings<br>• HIV screening<br>• Medical nutrition therapy services<br>• Obesity screening and counseling<br>• Prostate cancer screenings (PSA)<br>• Sexually transmitted infections screening and counseling<br>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>• Vaccines, including flu shots, hepatitis B shots, pneumococcal shots<br>• "Welcome to Medicare" preventive visit (one-time)<br>• Annual Wellness Visit<br>• Lung cancer screening<br>• Routine physical exam | **$0** copay for Medicaid-covered services<br>• Services include cervical cancer screenings, colonoscopies for individuals age 50 and older or high risk individuals, employment physicals if not covered by another source, gynecologic exams, prostate cancer screenings, and required physician visits for long-term-care facility residents<br>• Pap Smears and Pelvic Exams are covered once a year for women ages 16 and older and sexually active adolescents<br>• Mammography is covered for women starting at age 35<br>• Immunizations covered without limits |

*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 |
|---|---|---|
| | • Medicare diabetes prevention program<br>Any additional preventive services approved by Medicare during the contract year will be covered. | |
| **EMERGENCY CARE** | | |
| **Emergency room**<br>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 | **$3** copay for non-emergency services (applies to non-pregnant individuals age 21 and older who are not residing in a nursing facility or an intermediate care facility for persons with intellectual disabilities)** |
| **Urgently needed services**<br>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 | **$0** copay for Medicaid-covered services<br>• Covered when medically necessary and ordered by a doctor<br>• One mammogram screening for women between the ages of 35-40, and then once per 12-month period, thereafter<br>• Chest x-rays covered once per 12 month period for long term care facility residents |
| **Diagnostic radiology** | **$0** copay | |
| **Lab services** | **$0** copay | |
| **Diagnostic tests and procedures** | **$0** copay | |
| **Outpatient X-rays** | **$0** copay | |
| **Radiation therapy** | **$0** copay | |
| **HEARING SERVICES** | | |
| **Medicare-covered hearing** | **$0** copay | **$0** copay for Medicaid-covered services<br>• Covered for adults and children |

*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 |
|---|---|---|
| **Routine hearing** | In-network:<br>**HER953**<br>• **$0** copayment for routine hearing exams up to 1 per year.<br>• **$0** copayment for each Advanced level hearing aid up to 1 per ear every 3 years.<br><br>Out-of-network:<br>**HER953**<br>• **$0** copayment for routine hearing exams up to 1 per year.<br>• **$0** copayment for each Advanced level hearing aid up to 1 per ear every 3 years.<br>Hearing aid purchase includes:<br>• Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase<br>• 60-day trial period<br>• 3-year extended warranty<br>• 80 batteries per aid for non-rechargeable models<br>**You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (for TTY, dial 711).** | |

*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 |
|---|---|---|
| **DENTAL SERVICES**<br>The cost-share indicated below is what you pay for the covered service. | | |
| **Medicare-covered dental** | **$0** copay | **$3** copay per dental visit for non-pregnant individuals age 21 and older who are not residing in a nursing facility or intermediate care facility for people with intellectual disabilities**<br>• Check-up and cleanings - once every 6 months for individuals younger than age 21; and once every 12 months for adults<br>• Extractions, fillings, crowns and root canals based on medical necessity; may require prior authorization<br>• **$0** copay for Braces for individual younger than age 21 and must be prior authorized |
| **Routine dental**<br><br>Dental benefits may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**.<br><br>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. | In-network:<br>**DEN133**<br>• **$0** copayment for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.<br>• **$0** copayment for complete dentures, partial dentures up to 1 set(s) every 5 years.<br>• **$0** copayment for panoramic film or diagnostic x-rays up to 1 every 5 years.<br>• **$0** copayment for bitewing x-rays up to 1 set(s) per year.<br>• **$0** copayment for adjustments to dentures, crown, denture reline, intraoral x-rays up to 1 per year.<br>• **$0** copayment for amalgam and/or composite filling, periodic oral exam, prophylaxis (cleaning) up to 2 per year.<br>• **$0** copayment for necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year.<br>• **$1000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits.<br><br>Out-of-network:<br>**DEN133**<br>• **$0** copayment for comprehensive oral evaluation or periodontal exam up to 1 every 3 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 |
|---|---|---|
| | • **$0** copayment for complete dentures, partial dentures up to 1 set(s) every 5 years.<br>• **$0** copayment for panoramic film or diagnostic x-rays up to 1 every 5 years.<br>• **$0** copayment for bitewing x-rays up to 1 set(s) per year.<br>• **$0** copayment for adjustments to dentures, crown, denture reline, intraoral x-rays up to 1 per year.<br>• **$0** copayment for amalgam and/or composite filling, periodic oral exam, prophylaxis (cleaning) up to 2 per year.<br>• **$0** copayment for necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year.<br>• **$1000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits.<br>• 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 | **$2** per routine exam (individuals older than age 21 not residing in a nursing facility or an intermediate care facility for people with intellectual disabilities)**<br>• If you are 21-59 years old: one exam every 24 months. If you are 20 years old or younger, or 60 years old or older: once every 12 months<br>**$1** for eye glasses**<br>• If you are 21-59 years old: one pair of eyeglasses every 24 months. If you are 20 years old or younger, or 60 years old or older: one pair every 12 months.<br>• Contact lenses are covered with prior authorization<br>• These items must be prior authorized and be medically necessary |
| **Medicare-covered diabetic eye exam** | **$0** copay | |
| **Medicare-covered glaucoma screening** | **$0** copay | |
| **Medicare-covered eyewear (post-cataract)** | **$0** copay | |
| **Routine vision**<br><br>Refraction is only covered when billed as part of the routine vision exam.<br><br>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:<br>**VIS703**<br>• **$0** copayment for routine exam up to 1 per year.<br>• **$40** combined maximum benefit coverage amount per year for routine exam.<br>• **$400** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.<br>• Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year.<br>• Maximum benefit coverage amount is limited to one time use per year.<br><br>Out-of-network:<br>**VIS703**<br>• **$0** copayment for routine exam up to 1 per year.<br>• **$40** combined maximum benefit coverage amount per year for routine exam.<br>• **$400** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, | |

*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 |
|---|---|---|
| | fitting for eyeglasses-lenses and frames.<br>• Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year.<br>• Maximum benefit coverage amount is limited to one time use per year.<br>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. | |
| **MENTAL HEALTH SERVICES** | | |
| **Inpatient**<br>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 | **$0** copay with a medical need<br>• 52 hours per year for individuals age 21 and older with MHA certified providers<br>• 25 visits per year with non-MHA certified providers |
| **SKILLED NURSING FACILITY (SNF)** | | |
| Your plan covers up to 100 days in a SNF | **$0** copay | |
| **PHYSICAL THERAPY** | | |
| | **$0** copay | **$0** copay for Medicaid-covered services<br>• 30 visits for physical and occupational therapy combined every 12 months. |

*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 |
|---|---|---|
| **AMBULANCE** | | |
| **Ambulance** | **$0** copay | **$0** copay for Medicaid-covered services<br>• Ambulance services are covered for medical emergencies |
| **TRANSPORTATION** | | |
| | **$0** copay for plan approved location up to 100 one-way trip(s) per year.<br>This benefit is not to exceed 75 miles per trip.<br><br>The member *must* contact transportation vendor to arrange transportation. | **$0** copay for transportation to Medicaid-covered services |

## 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 | For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copays and deductibles for Medicare Part B Drugs |
| **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 | **$0** copay for generics<br>**$3** copay for drugs requiring prior authorization**<br>**$2** copay for most brand name drugs**<br><br>Medicaid may cover some drugs that are not covered by Part D. Contact the Ohio Department of Medicaid (ODM) agency for questions on drug coverage.<br><br>Prior authorization required for name-brand prescription drugs when generic ones are available. |

**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®<br>**Retail:** To find the preferred cost-share retail pharmacies near you, go to **Humana.com/pharmacyfinder** | |
| **Standard cost-sharing** | **Mail order:** Walmart Mail<br>**Retail:** All other network retail pharmacies | |
| **For generic drugs** (including brand drugs treated as generic), either: | **30-day supply**<br>**$0** copay; or<br>**$1.35** copay; or<br>**$3.95** copay; or<br>**15%** of the cost | **90-day supply**<br>**$0** copay; or<br>**$1.35** copay; or<br>**$3.95** copay; or<br>**15%** of the cost |
| **For all other drugs**, either: | **$0** copay; or<br>**$4** copay; or<br>**$9.85** copay; or<br>**15%** of the cost | **$0** copay; or<br>**$4** copay; or<br>**$9.85** copay; or<br>**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 | **$0** copay for Medicaid-covered services<br>• One long-term care facility visit per month<br>• One nail debridement per 60 days |
| **Medicare-covered chiropractic services** | **$0** copay | **$0** copay for Medicaid-covered services<br>• Covered for adults and children<br>• 15 visits per year for adults<br>• 30 visits per year for children younger than age 21 |
| **MEDICAL EQUIPMENT/SUPPLIES** | | |
| **Durable medical equipment (like wheelchairs or oxygen)** | **$0** copay | **$0** copay for Medicaid-covered services<br>• Requires prior authorization |
| **Medical Supplies** | **$0** copay | |
| **Prosthetics (artificial limbs or braces)** | **$0** copay | |
| **Diabetic monitoring supplies** | **$0** copay | |
| **REHABILITATION SERVICES** | | |
| **Occupational and speech therapy** | **$0** copay | **$0** copay for Medicaid-covered services<br>• 30 visits for speech/language pathology and audiology services combined per 12 months<br>• 30 visits for physical and occupational therapy combined per 12 months |
| **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 H5525-046 (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 Ohio Department of Medicaid (ODM) 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 Ohio Department of Medicaid (ODM): 1-800-324-8680 (TTY: 711).

| BENEFIT | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID STATE PLAN |
|---|---|---|
| **MEDICAL SERVICES** | | |
| **Private Duty Nursing (PDN)** | Not covered. | **$0** copay for Medicaid-covered services<br>• Continuous nursing care in your home<br>• A PDN visit is more than 4 hours and less than or equal to 12 hours<br>• PDN nursing must be prior authorized<br>• There are defined service limits |
| **Family Planning Visits and Services** | Not covered. | **$0** copay for Medicaid-covered services<br>• As needed |
| **Dermatology (Skin) Services** | See "Doctor visits" benefit in the "Covered Medical and Hospital Benefits" chart above | **$0** copay for Medicaid-covered services<br>• Must be medically necessary and related to a disease or condition |
| **Healthchek** | Not covered. | **$0** copay for Medicaid-covered services<br>Under age 21<br>• 13 well-child visits by age 3 and then one every 12 months |
| **Physical Exam Required for Job Placement** | Not covered. | **$0** exam is covered if not offered free of charge by employer |

| | | |
|---|---|---|
| **Pregnancy and Hospital Services**<br>(including prenatal and postpartum doctor visits, ultrasounds, childbirth classes, labor & delivery, hospital stay, and health care for baby.) | See "Acute Inpatient care", "Doctor visits" and "Diagnostic services, labs and imaging" benefits in the "Covered Medical and Hospital Benefits" chart above<br><br>Health care services for the baby are not covered. | **$0** copay for Medicaid-covered services<br>• Medicaid pays for all pregnancy related services when they are needed. These services include postpartum check-ups for mom and health care and immunizations for baby |
| **PRODUCTS AND DEVICES** | | |
| **Dentures and Partial Plates** | See "Dental" benefits in the "Covered Medical and Hospital Benefits" chart above | **$3** copay per visit for non-pregnant individuals age 21 and older who are not residing in a nursing facility or intermediate care facility for people with intellectual disabilities**<br>• Dentures may be replaced based upon medical necessity; dentures and partial plates must be prior authorized by the State |
| **Eyeglasses** | See "Vision" benefits in the "Covered Medical and Hospital Benefits" chart above | **$2** copay for exam and **$1** copay for eyeglasses (individuals older than age 21 not residing in a nursing facility or an intermediate care facility for people with intellectual disabilities). Beneficiaries 21-59 years old: one pair every 24 months.**<br>• One exam and eyeglasses for individuals younger than 21 and older than age 60<br>• One exam and eyeglasses every 24 months for individuals between the ages of 21 and 59<br>• Contact lenses covered with prior authorization |
| **Hearing Aids** | | **$0** copay<br>• One conventional hearing aid every four years; one digital or programmable hearing aid every five years<br>• Hearing aids with prior authorization |

| | | |
|---|---|---|
| **TRANSPORTATION** | | |
| **Non-Emergency Medical Transportation Services** | See "Transportation" benefit in the "Covered Medical and Hospital Benefits" chart above | **$0** copay<br>Non-emergency transportation to and from Medicaid-covered services through the County Department of Job and Family Services<br>• When medically necessary and patient cannot be transported by any other type of transportation |
| **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 | Your Medicaid caseworker will determine a Patient Liability amount based on your income excluding certain deductions<br>• These services are available to those who need long-term care in an institution |
| **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 | Your Medicaid caseworker will determine a Patient Liability amount based on your income excluding certain deductions<br>• These services are available to those who need long-term care in an institution |
| **Nursing Facility Services, other than in an Institution for Mental Diseases** | See "Skilled Nursing" benefit in the "Covered Medical and Hospital Benefits" chart above | Your Medicaid caseworker will determine a Patient Liability amount based on your income excluding certain deductions<br>• These services are available to those who need long-term care in an institution |
| **OTHER MEDICAID-COVERED SERVICES** | | |
| **Home Health Care** | **$0** copay | **$0** copay for Medicaid-covered services. Part-time daily living care in your home.<br>• Nursing services and skilled therapies available when medically necessary and ordered by your doctor |

| | |
|---|---|
| **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. |

**HOME AND COMMUNITY BASED WAIVER SERVICES - LONG-TERM HOME AND COMMUNITY CARE OPTIONS OR "WAIVER SERVICES"**

If you need long-term care but want to stay in your home, you may be able to do so through one of the home and community-based services waiver programs. Waiver services are limited to individuals who meet additional waiver eligibility criteria. There is **$0** copay for Medicaid-covered services. For more information on waiver services and eligibility for waiver programs, contact the Ohio Department of Medicaid (ODM) at 1-800-324-8680 (TTY: 711).

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

(a) Individuals under the age of 21 years.
(b) Pregnant women – for pregnancy – related services, including services for medical conditions that may complicate the pregnancy. This exemption includes the six week period following the end of the pregnancy.
(c) Individuals receiving services in an inpatient hospital setting, long-term care facility, or other medical institution if, as a condition of receiving services in the institution, that individual is required to spend all of his or her income for medical care costs with the exception of the minimal amount required for personal needs.
(d) Individuals who require emergency services after the sudden onset of a medical condition which, if left untreated, would place their health in serious jeopardy.
(e) Individuals receiving services or supplies related to family planning.

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 Ohio Medicaid coverage information, please visit the Ohio Department of Medicaid (ODM) website at **http://jfs.ohio.gov/ohp/** or call the Medicaid Hotline at 1-800-324-8680 (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 with certain special needs plan (SNP) specific conditions or following an inpatient stay in the hospital or nursing facility.

### Over-the-Counter (OTC) mail order

**$150** maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products.

### Personal Emergency Response System

The personal emergency response system provides help in emergency situations. GoSafe Mobile personal help button functions both in and out of the home. GoSafe uses two way voice communication & five location seeking technologies to send help quickly to wherever the member is located.

### 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

# Notes

# Notes

# Important!

## At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-877-320-1235** 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

HumanaChoice SNP-DE H5525-046
(PPO D-SNP)
H5525046000 ENG
Select counties in Ohio

Humana.com

H5525046000SB22