2022

Summary of Benefits

HumanaChoice SNP-DE H5525-048 (PPO D-SNP)

Indiana
Select counties in Indiana

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 H5525-048 (PPO D-SNP)

Indiana
Select counties in Indiana

Humana®

Our service area includes the following county/counties in Indiana: Benton, Blackford, Carroll, Cass, Clay, Crawford, Daviess, Dearborn, Decatur, Dubois, Elkhart, Fayette, Fountain, Franklin, Fulton, Gibson, Greene, Henry, Jasper, Jay, Jefferson, Jennings, Knox, Lawrence, Martin, Miami, Newton, Ohio, Orange, Owen, Parke, Perry, Pike, Posey, Pulaski, Randolph, Ripley, Rush, Scott, Spencer, Starke, Steuben, Sullivan, Switzerland, Union, Vanderburgh, Vermillion, Vigo, Warren, Warrick, Washington, Wayne, White.

Let's talk about HumanaChoice SNP-DE H5525-048 (PPO D-SNP)

Find out more about the HumanaChoice SNP-DE H5525-048 (PPO D-SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice SNP-DE H5525-048 (PPO D-SNP) is a Coordinated Care plan with a Medicare contract and a contract with the Indiana 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 H5525-048 (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 H5525-048 (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 Indiana Medicaid. If you receive both Medicare and Medicaid benefits, this means you are a dual eligible.

HumanaChoice SNP-DE H5525-048 (PPO D-SNP) may enroll dual eligibles who are QMB, QMB Plus, SLMB Plus and FBDE.

Plan name:

HumanaChoice SNP-DE H5525-048 (PPO D-SNP)

More about HumanaChoice SNP-DE H5525-048 (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 Indiana 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 Indiana 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 Indiana Medicaid coverage information, please visit the Indiana Medicaid website at **http://www.indianamedicaid.com/** or call the Medicaid Hotline at 1-800-457-4584 (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 Indiana 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 Indiana Medicaid 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	
OUTPATIENT HOSPITAL COVERAGE		
Outpatient surgery at outpatient hospital	**$0** copay	**$3** copay/non-emergency visit in ER
Outpatient surgery at ambulatory surgical center	**$0** copay	
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	
Specialists	**$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	

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
	• 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 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	

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
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	
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	

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
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	

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 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 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: **DEN133** • **$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 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, crown, denture reline, intraoral x-rays up to 1 per year. • **$0** copayment for amalgam and/or composite filling, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **$0** copayment for necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. • **$1000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits. Out-of-network: **DEN133** • **$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.	

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 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 adjustments to dentures, crown, denture reline, intraoral x-rays up to 1 per year. • **$0** copayment for amalgam and/or composite filling, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **$0** copayment for necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. • **$1000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.	
VISION SERVICES		
Medicare-covered vision services	**$0** copay	
Medicare-covered diabetic eye exam	**$0** copay	
Medicare-covered glaucoma screening	**$0** copay	
Medicare-covered eyewear (post-cataract)	**$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
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 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	

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
	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	
SKILLED NURSING FACILITY (SNF)		
Your plan covers up to 100 days in a SNF	**$0** copay	
PHYSICAL THERAPY		
	$0 copay	Covered • 12 hours/30 days or 30 therapy sessions/month in combination with other therapy providers if ordered by physician prior to hospital discharge
AMBULANCE		
Ambulance	**$0** copay	**$.50** - **$2** copay/non-emergency transport, depending on payment
TRANSPORTATION		
	$0 copay for plan approved location up to 100 one-way trip(s) per year. This benefit is not to exceed 75 miles per trip. The member *must* contact transportation vendor to arrange transportation.	

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 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	
PRESCRIPTION DRUGS		
Medicare Part D Drugs	See chart below for plan coverage information for prescription drugs	**$3** copay** • Medicaid may cover some drugs that are not covered by Part D. Contact the Indiana Medicaid agency for questions on drug coverage. • Medicaid covers prescription drugs not covered by a Medicare Prescription Drug Plan.

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. You will always pay **$0** for Tier 1 drugs on this plan at a Preferred Cost-Sharing Retail or Preferred Cost-Sharing Mail Order Pharmacy.

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	
Medicare-covered chiropractic services	**$0** copay	
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**$0** copay	
Medical Supplies	**$0** copay	**$1950** maximum benefit/year for incontinence products and products must be obtained from a contracted vendor
Prosthetics (artificial limbs or braces)	**$0** copay	Covered
Diabetic monitoring supplies	**$0** copay	
REHABILITATION SERVICES		
Occupational and speech therapy	**$0** copay	Covered • Occupational Therapy – 30 therapy sessions/month in combination with other therapy providers if ordered by physicians prior to hospital discharge • Speech Therapy – 1 audiological testing and evaluation/3 years – 30 therapy sessions/month in combination with other therapy providers if ordered by physician prior to hospital discharge
Cardiac rehabilitation	**$0** copay	
Pulmonary rehabilitation	**$0** copay	
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	

	WHAT YOU PAY ON THIS HUMANA PLAN IN AND OUT-OF-NETWORK	MEDICAID USUAL LIMITS AND COPAYS
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 H5525-048 (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 Indiana 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 Indiana Medicaid: 1-800-457-4584 (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	Covered • **$600** maximum benefit/year included with dental services
Eyeglasses	See "Vision" benefit in the "Covered Medical and Hospital Benefits" chart above	Covered • 1 pair eyeglasses/5 years, age-specific minimum diopter correction required for initial and replacement eyeglasses
Hearing Aids	See "Hearing" benefit in the "Covered Medical and Hospital Benefits" chart above	Covered • 1 hearing aid/5 years
TRANSPORTATION		
Non-Emergency Medical Transportation Services	See "Transportation" benefit in the "Covered Medical and Hospital Benefits" chart above	**$0.50** - **$2.00** / trip depending on payment** • 20 one-way trips of less than 50 miles/year per rolling 12 month period

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	**$0** copay • Services limited to hospital settings, 60 therapeutic leave days/year
Inpatient Psychiatric Services, under age 21	See "Mental Health" benefit in the "Covered Medical and Hospital Benefits" chart above	**$0** copay • 14 therapeutic leave days/year
Intermediate Care Facility Services for Individuals with Intellectual Disabilities	Not Covered	**$0** copay • 15 hospital leave days/hospitalization • 60 therapeutic leave days/year
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 • 15 consecutive hosp leave days/hosp • 30 therapeutic leave days/year

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 Indiana Medicaid at 1-800-457-4584 (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 Indiana Medicaid coverage information, please visit the Indiana Medicaid website at **http://www.indianamedicaid.com** or call the Medicaid Hotline at 1-800-457-4584 (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.

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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