

2022

Summary of Benefits

HumanaChoice SNP-DE H5216-267 (PPO D-SNP)

Colorado

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+ and SLMB+.

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Colorado

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Our service area includes the following county/counties in Colorado: Adams, Alamosa, Arapahoe, Archuleta, Bent, Boulder, Broomfield, Chaffee, Clear Creek, Conejos, Costilla, Crowley, Custer, Delta, Denver, Dolores, Douglas, El Paso, Elbert, Fremont, Gilpin, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Jefferson, La Plata, Lake, Larimer, Las Animas, Lincoln, Logan, Mesa, Mineral, Montezuma, Montrose, Morgan, Otero, Ouray, Park, Pueblo, Rio Blanco, Rio Grande, Saguache, San Juan, San Miguel, Summit, Teller, Washington, Weld.



Let's talk about HumanaChoice SNP-DE H5216-267 (PPO D-SNP)

Find out more about the HumanaChoice SNP-DE H5216-267 (PPO D-SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice SNP-DE H5216-267 (PPO D-SNP) is a Coordinated Care plan with a Medicare contract and a contract with the Health First Colorado (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 H5216-267 (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 H5216-267 (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 Health First Colorado (Medicaid). If you receive both Medicare and Medicaid benefits, this means you are a dual eligible.

HumanaChoice SNP-DE H5216-267 (PPO D-SNP) may enroll dual eligibles who are QMB, QMB+ and SLMB+.

Plan name:

HumanaChoice SNP-DE H5216-267 (PPO D-SNP)

More about HumanaChoice SNP-DE H5216-267 (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 Health First Colorado (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 Health First Colorado (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 Colorado Medicaid coverage information, please visit the Health First Colorado (Medicaid) website at **<https://www.healthfirstcolorado.com/benefits-services/>** or call the Medicaid Hotline at 1-800-221-3943 (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 Colorado 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 Health First Colorado (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	\$10 Copayment per covered day or 50% of the averaged allowable daily rate, whichever is less Children under age of 19 and pregnant women do not have co-pays
OUTPATIENT HOSPITAL COVERAGE		
Outpatient surgery at outpatient hospital	\$0 copay	\$4 Copayment per visit Children under age of 19 and pregnant women do not have co-pays
Outpatient surgery at ambulatory surgical center	\$0 copay	\$0 Copayment per visit Children under age of 19 and pregnant women do not have co-pays
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	\$0 copay	\$2 Copayment per visit
Specialists	\$0 copay	Children under age of 19 and pregnant women do not have co-pays

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.)

H5216267000

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:

\$0 Copayment for Medicaid covered preventative care visits

- 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)
- 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

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

- Medicare diabetes prevention program
- Any additional preventive services approved by Medicare during the contract year will be covered.

MEDICAID USUAL LIMITS AND COPAYS

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

\$0 Copayment if determined an emergency

\$6 Copayment per visit if not emergency

Children under age of 19 and pregnant women do not have co-pays

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

\$2 Copayment per visit if not part of an emergency room

Children under age of 19 and pregnant women do not have co-pays

DIAGNOSTIC SERVICES, LABS AND IMAGING

Diagnostic mammography

\$0 copay

Diagnostic radiology

\$0 copay

Lab services

\$0 copay

\$1 Copayment per date of service

Diagnostic tests and procedures

\$0 copay

\$2 Copayment for diagnostic or treatment colonoscopy

Outpatient X-rays

\$0 copay

\$1 Copayment per date of service

Radiation therapy

\$0 copay

\$4 Copayment if performed in an outpatient hospital

\$2 Copayment if performed in a doctor's office

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.)

H5216267000

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

MEDICAID USUAL LIMITS AND COPAYS

HEARING SERVICES

Medicare-covered hearing

\$0 copay

\$0 Copayment for ages 20 and under for hearing aids or Cochlear implants

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.

\$0 Copayment (all ages) for replacement of existing Cochlear implant if broken or lost

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).

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.)

H5216267000

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

MEDICAID USUAL LIMITS AND COPAYS

DENTAL SERVICES

The cost-share indicated below is what you pay for the covered service.

Medicare-covered dental

\$0 copay

\$0 Copayment

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:
DEN388

- **0%** coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.
- **0%** coinsurance for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years.
- **0%** coinsurance for complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years.
- **0%** coinsurance for crown up to 1 per tooth per lifetime.
- **0%** coinsurance for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.
- **0%** coinsurance for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year.
- **0%** coinsurance for emergency treatment for pain, fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year.
- **0%** coinsurance for periodontal maintenance up to 4 per year.
- **0%** coinsurance for amalgam and/or composite filling, necessary anesthesia with covered service, simple or

Annual adult (21 years old and up) benefit of up to \$1,500 per state fiscal year which runs from July 1 – June 30

Emergency and dentures benefits are not subject to this limit

There is no limit for children's services (21 years old and under)

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

surgical extraction up to unlimited per year.

- **\$4000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits.

Out-of-network:

DEN388

- **0%** coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.
- **0%** coinsurance for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years.
- **0%** coinsurance for complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years.
- **0%** coinsurance for crown up to 1 per tooth per lifetime.
- **0%** coinsurance for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.
- **0%** coinsurance for adjustments to dentures, denture rebase, denture relines, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year.
- **0%** coinsurance for emergency treatment for pain, fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year.
- **0%** coinsurance for periodontal maintenance up to 4 per year.
- **0%** coinsurance for amalgam and/or composite filling,

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.)

H5216267000

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

MEDICAID USUAL LIMITS AND COPAYS

necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year.

- **\$4000** 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

\$2 Copayment per visit

Medicare-covered diabetic eye exam

\$0 copay

Children under age of 19 and pregnant women do not have co-pays

Medicare-covered glaucoma screening

\$0 copay

Adult vision care benefit includes medically necessary eye exams, glasses and contact lenses only after surgery

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.

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.)

H5216267000

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

MEDICAID USUAL LIMITS AND COPAYS

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

Out-of-network:

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 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 Copayment

Outpatient group and individual therapy visits

\$0 copay

\$0 Copayment

SKILLED NURSING FACILITY (SNF)

Your plan covers up to 100 days in a SNF

\$0 copay

\$0 Copayment

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	\$10 Copayment per inpatient day \$4 Copayment per visit in outpatient hospital \$2 Copayment per visit in physician office \$0 Copayment per visit in therapy clinic or rehab agency Children under age of 19 and pregnant women do not have co-pays
AMBULANCE		
Ambulance	\$0 copay	\$0 Copayment
TRANSPORTATION		
	\$0 copay for plan approved location up to 36 one-way trip(s) per year. This benefit is not to exceed 125 miles per trip. The member <i>must</i> contact transportation vendor to arrange transportation.	\$0 Copayment



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	\$4 Copayment – Outpatient hospital \$2 Copayment – Physician's office
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

\$3 Copayment per prescription or refill for brand name or generic medicines

Pregnant women and children do not have to pay co-pays for prescription drugs

Medicaid may cover some drugs that are not covered by Part D. Contact the Health First Colorado (Medicaid) agency for questions on drug 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	90-day supply
	\$0 copay; or \$1.35 copay; or \$3.95 copay; or 15% of the cost	\$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	\$1 a day Copayment for some durable medical equipment
Medical Supplies	\$0 copay	Children under age of 19 and pregnant women do not have co-pays
Prosthetics (artificial limbs or braces)	\$0 copay	
Diabetic monitoring supplies	\$0 copay	
REHABILITATION SERVICES		
Occupational and speech therapy	\$0 copay	Inpatient \$10 Copayment per inpatient day Outpatient \$0 Copayment – In Home \$4 Copayment per visit – Outpatient hospital \$2 Copayment per visit – Physician office \$0 Copayment per visit – Therapy clinic or Rehab agency
Cardiac rehabilitation	\$0 copay	
Pulmonary rehabilitation	\$0 copay	
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	\$0 copay	\$0 Copayment for telemedicine but co-pays may apply for other service provided
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 Medicaid services not covered by Medicare. HumanaChoice SNP-DE H5216-267 (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 above are covered by Medicare. The benefits described below are covered by Medicaid. For each benefit listed below, you can see what the Health First Colorado (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 Health First Colorado (Medicaid): 1-800-221-3943(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
Eyeglasses	See "Vision" benefit in the "Covered Medical and Hospital Benefits" chart above	\$2 Copayment per visit Adult vision care benefit includes, medically necessary eye exams, glasses and contact lenses only after surgery
Hearing Aids	See "Hearing" benefit in the "Covered Medical and Hospital Benefits" chart above	\$0 Copayment for ages 20 and under for hearing aids or Cochlear implants \$0 Copayment (all ages) for replacement of existing Cochlear implant if broken or lost
TRANSPORTATION		
Non-Emergency Medical Transportation Services	See "Transportation" benefit in the "Covered Medical and Hospital Benefits" chart above	\$0 Copayment
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 Copayment
Inpatient Psychiatric Services, under age 21	See "Mental Health" benefit in the "Covered Medical and Hospital Benefits" chart above	\$0 Copayment

Intermediate Care Facility Services for Individuals with Intellectual Disabilities	Not Covered	
Nursing Facility Services, other than in an Institution for Mental Diseases	See "Skilled Nursing" benefit in the "Covered Medical and Hospital Benefits" chart above	
COMMUNITY BASED LONG TERM CARE AND MENTAL HEALTH SERVICES		
Personal Care Services	Not Covered	
Certain Mental Health Services including:	Not Covered	\$0 Copayment Outpatient Day Treatment – Non residential Clinic Services – Case Management Biologically – based mental illnesses and disorders
Medical Social Services	Not Covered	
Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs	Not Covered	
Comprehensive Medicaid Case Management	Not Covered	
Adult Day Health Care	Not Covered	
Personal Emergency Response System	Not Covered	
OTHER MEDICAID COVERED SERVICES		
Over-the-Counter (OTC) benefits	See "Over-the-Counter benefits" benefit on the "More benefits with your plan" page later in this document	
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 Health First Colorado (Medicaid) at 1-800-221-3943 (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 7/1/2021. All Medicaid covered services are subject to change at any time. For the most current Health First Colorado (Medicaid) coverage information, please visit the Health First Colorado (Medicaid) website at or call the Medicaid Hotline at 1-800-221-3943 (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

\$75 automatically loaded every month to spend at participating retailers toward the purchase of approved 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.

Routine foot care

- In-network: **\$0** copay.
- Out-of-network: **\$0** copay.
- Combined in- and out-of-network visit limit: 12 visits per year.

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) mail order

\$200 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](https://www.humana.com/finder/search)** or call us at the number listed at the beginning of this booklet and we will send you one.



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

To find out more about the coverage and costs of Original Medicare, look in the current “Medicare & You” handbook. View it online at <http://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

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

Medicare-covered eye refractions during a specialist medical visit are not covered.

Telehealth services shown are in addition to the Original Medicare covered telehealth. Your cost may be different for Original Medicare telehealth.

Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services are for informational purposes only and should not be construed as medical advice. Please refer to your evidence of coverage for additional details on what your plan may cover or other rules that may apply.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Out-of-network/non-contracted providers are under no obligation to treat Humana members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Important!

At Humana, it is important you are treated fairly.

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

- You may file a complaint, also known as a grievance:
Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you.

1-877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

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

العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

HumanaChoice SNP-DE H5216-267
(PPO D-SNP)

H5216267000 ENG

Colorado

