2024

Summary of Benefits

HumanaChoice SNP-DE H5970-026 (PPO D-SNP)

Bronx

Our service area includes the following county/counties in New York: Bronx.

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

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. 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.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month. The Part A/ Part B premiums may be paid for by the New York State Department of Health (SDOH) (Medicaid).
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025.
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, 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 FBDE, QMB, QMB+.

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Let's talk about HumanaChoice SNP-DE H5970-026 (PPO D-SNP)

Find out more about the HumanaChoice SNP-DE H5970-026 (PPO D-SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice SNP-DE H5970-026 (PPO D-SNP) is a Coordinated Care plan LPPO with a Medicare contract and a contract with the New York State Department of Health (SDOH) (Medicaid) program. 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, please refer to the plan's Evidence of Coverage on our website, **Humana.com/plandocuments**.

As a member, it's a good idea to select a doctor as your Primary Care Provider(PCP). HumanaChoice SNP-DE H5970-026 (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 H5970-026 (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 New York State Department of Health (SDOH) (Medicaid). If you receive both Medicare and Medicaid benefits, this means you are dual eligible.

HumanaChoice SNP-DE H5970-026 (PPO D-SNP) may enroll FBDE, QMB, QMB+.

Full Benefit Dual Eligible (FBDE): Financial assistance may be available to pay Medicare Part A Premiums, and/or Medicare Part B Premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

Qualified Medicare Beneficiary (QMB): Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).

Qualified Medicare Beneficiary Plus (QMB+): Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

Plan name:

HumanaChoice SNP-DE H5970-026 (PPO D-SNP)

More about HumanaChoice SNP-DE H5970-026 (PPO D-SNP)

Depending on your level of eligibility for assistance under your state Medicaid program, you may or may not be subject to cost-sharing requirements. The Medicaid Benefit Comparison chart shows specific benefits that Medicaid may cover for some dual eligible members. You will work with your Humana care coordinator to understand and access these benefits. The Covered Medical and Hospital Benefits chart shows the benefits you will receive from Humana.

Be sure to show the New York State Department of Health (SDOH) (Medicaid) ID card in addition to your Humana membership card to make your provider aware that you also have Medicaid coverage. You may be required to pay a small Medicaid specific co-payment. 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 New York State Department of Health (SDOH) (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**.

Medicaid benefits last validated on 07/01/2023 and are subject to change. For the most current New York Medicaid coverage information, please visit the New York State Department of Health (SDOH) (Medicaid) website at **https://www.health.ny.gov/health_care/medicaid/members/** or call the Medicaid Hotline at 1-800-541-2831 (toll free) .

A healthy partnership

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

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Monthly Premium, Deductible and Limits

Monthly plan premium	**$0** You must keep paying your Medicare Part B premium. Your Part A and/or Part B premium may be paid on your behalf by the New York State Department of Health (SDOH) (Medicaid) Program.
Medical deductible * You pay the same amount as you would with Original Medicare. In 2023, the amounts are as listed. These amounts may change in 2024.	**$0** or **$226*** combined in-network and out-of-network deductible for Part B services, depending on your level of Medicaid eligibility. The following services listed are excluded from the combined in-network and out-of-network Part B deductible: In-Network only: Ambulance Services Chemotherapy Drugs and Administration Diabetic Monitoring Supplies Medicare Part B Covered Drugs Part A Services (IP, Skilled Nursing and Home Health) Both In-Network and Out-of-Network: Emergency Room Services Medicare Covered Preventive Services Services not covered by Original Medicare Urgently Needed Services at Urgent Care Centers
Pharmacy (Part D) deductible	**$0** deductible if you receive "Extra Help".
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for covered medical services for the year	**$8,850** in-network **$13,300** combined in- and out-of-network If you are eligible for Medicare cost-sharing assistance under the New York State Department of Health (SDOH) (Medicaid) you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Covered Medical and Hospital Benefits

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
INPATIENT HOSPITAL CARE		
	$0 copay	**$0** or **30%** of the cost
OUTPATIENT HOSPITAL COVERAGE Services listed below may also be covered at other places of treatment. Please refer to specific services listed in this document for additional information.		
Advanced imaging services (MRI, MRA, PET and CT scan)	**$0** copay	**$0** or **30%** of the cost

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.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
Basic radiological services (X-rays)	**$0** copay	**$0** or **30%** of the cost
Cardiac rehabilitation services	**$0** copay	**$0** or **30%** of the cost
Chemotherapy drugs	**$0** copay	**$0** or **30%** of the cost
Diagnostic colonoscopy	**$0** copay	**$0** or **30%** of the cost
Diagnostic mammography	**$0** copay	**$0** or **30%** of the cost
Diagnostic procedures and tests - other	**$0** copay	**$0** or **30%** of the cost
Lab services	**$0** copay	**$0** or **30%** of the cost
Medicare Part B covered drugs	**$0** copay	**$0** or **30%** of the cost
Mental health services	**$0** copay	**$0** or **30%** of the cost
Nuclear medicine services	**$0** copay	**$0** or **30%** of the cost
Occupational therapy	**$0** copay	**$0** or **30%** of the cost
Opioid treatment program services	**$0** copay	**$0** or **30%** of the cost
Physical therapy	**$0** copay	**$0** or **30%** of the cost
Pulmonary rehabilitation services	**$0** copay	**$0** or **30%** of the cost
Renal dialysis services	**$0** copay	**$0** or **20%** of the cost
Sleep study (facility based)	**$0** copay	**$0** or **30%** of the cost
Speech therapy	**$0** copay	**$0** or **30%** of the cost
Substance abuse services	**$0** copay	**$0** or **30%** of the cost
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)	**$0** copay	**$0** or **30%** of the cost
Surgery services	**$0** copay	**$0** or **30%** of the cost
Therapeutic radiology (Radiation therapy)	**$0** copay	**$0** or **30%** of the cost
Wound care	**$0** copay	**$0** or **30%** of the cost
AMBULATORY SURGERY CENTER		
Diagnostic colonoscopy	**$0** copay	**$0** or **30%** of the cost
Surgery services	**$0** copay	**$0** or **30%** of the cost

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**$0** or **30%** of the cost
Specialist	**$0** copay	**$0** or **30%** of the cost
PREVENTIVE CARE		
	Our plan covers many preventive services at no cost including: • Abdominal aortic aneurysm screening • Alcohol misuse screening & counseling • Annual Wellness Visit (AWV) • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit • Cardiovascular disease screenings • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training • Glaucoma screening • HIV screening • Immunizations • Lung Cancer Screening • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy • Prostate cancer screening exams • Routine Physical Exam • Sexually transmitted infections (STIs) screening and counseling	**$0** copay or **30%** of the cost, depending on the service and where service is provided Any additional preventive services approved by Medicare during the contract year will be covered.

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
	• Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • "Welcome to Medicare" preventive visit 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	**$0** or **$100** copay
Physician and professional services at emergency room	**$0** copay	**$0** copay
URGENTLY NEEDED SERVICES		
Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$0** copay	**$0** or **$55** copay at an urgent care center
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Advanced imaging services (MRI, MRA, PET and CT scan)		
• Freestanding radiological facility	**$0** copay	**$0** or **30%** of the cost
• Primary care physician's office	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
Basic radiological services (X-rays)		
• Freestanding radiological facility	**$0** copay	**$0** or **30%** of the cost
• Primary care physician's office	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
• Urgent care center	**$0** copay	**$0** or **$55** copay

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
Diagnostic colonoscopy at an ambulatory surgery center	**$0** copay	**$0** or **30%** of the cost
Diagnostic mammography		
• Freestanding radiological facility	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
Diagnostic procedures and tests		
• Primary care physician's office	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
• Urgent care center Diagnostic tests and procedures	**$0** copay	**$0** or **$55** copay
Lab services		
• Freestanding laboratory	**$0** copay	**$0** or **30%** of the cost
• Primary care physician's office	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
• Urgent care center	**$0** copay	**$0** or **$55** copay
Nuclear medicine and services at a freestanding radiological facility	**$0** copay	**$0** or **30%** of the cost
Sleep study		
• Member's home	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
Therapeutic radiology (Radiation therapy)		
• Freestanding radiological facility	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**$0** copay	**$0** or **30%** of the cost
Mandatory supplemental hearing benefit	**HER763** • **$0** copay for fitting/evaluation, routine hearing exams up to 1 per year. • **$500** combined in and out of network maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year.	**HER763** • **$0** copay for fitting/evaluation, routine hearing exams up to 1 per year. • **$500** combined in and out of network maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear 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.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
		• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement. See Chapter 2 Payment Requests Contact Information in your Evidence of Coverage or visit **Humana.com** for information on requesting reimbursement.
DENTAL SERVICES		
Medicare-covered dental	**$0** copay	**$0** or **30%** of the cost
Mandatory supplemental dental benefit Limitations and exclusions may apply. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. Dental benefits under this plan may not cover all ADA procedure codes. Any services received that are not listed will not be covered by the plan and will be the member's responsibility. The member is responsible for any amount above the dental coverage limit. Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. Information regarding each plan is available at **Humana.com/sb**.	**DEN245** • **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. • **$0** copay for bridge recementation, bridges-pontic, crown recementation, panoramic film or diagnostic x-rays up to 1 every 5 years. • **$0** copay for bridges-crown up to 2 every 5 years. • **$0** copay for crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime.	**DEN245** • **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. • **$0** copay for bridge recementation, bridges-pontic, crown recementation, panoramic film or diagnostic x-rays up to 1 every 5 years. • **$0** copay for bridges-crown up to 2 every 5 years. • **$0** copay for crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime.

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.

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule Out-of-network dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Members may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Please see below for provider locator instructions. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement. The coinsurance level will apply to the average negotiated in-network fee schedule (INFS) in your area. See Chapter 2 Payment Requests Contact Information in your Evidence of Coverage or visit **Humana.com** for information on requesting reimbursement. When visiting an out-of-network provider there could be a difference between Humana's reimbursement and the dentist's charges. Members are	• **$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • **$0** copay for emergency diagnostic exam up to 1 per year. • **$0** copay for emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **$0** copay for periodontal maintenance up to 4 per year. • **$0** copay for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. • **$1,500** combined maximum benefit coverage amount per year for all preventive and comprehensive benefits.	• **$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • **$0** copay for emergency diagnostic exam up to 1 per year. • **$0** copay for emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **$0** copay for periodontal maintenance up to 4 per year. • **$0** copay for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. • **$1,500** combined maximum benefit coverage amount per year for all preventive and comprehensive benefits. • 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.

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
responsible for this difference when visiting an out-of-network provider; this is known as balanced billing. The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at **Humana.com** > Find a doctor > Select the Dentist icon from the menu > Enter Zip code > From the Distance drop down select the preferred distance > From the look up method select All Dental Networks > Then select HumanaDental Medicare.		
VISION SERVICES		
Eyewear (post cataract surgery)	**$0** copay	**$0** or **30%** of the cost
Medicare-covered diabetic eye exam	**$0** copay	**$0** or **30%** of the cost
Medicare-covered vision services The provider location for Medicare-covered vision can be found at **Humana.com** > Find a Doctor > select the Medical icon > enter Zip Code > select look up Method > Medicare or Medicare-Medicaid > select your plan Network > select Search Category > Specialty Physician.	**$0** copay	**$0** or **30%** of the cost
Mandatory supplemental vision benefit The provider locator for the Humana Medicare Insight Network for Mandatory Supplemental benefit vision can be found at **Humana.com** > Find	**VIS703** • **$0** copay for routine exam up to 1 per year. • **$40** combined maximum benefit coverage amount per year for routine exam.	**VIS703** • **$0** copay for routine exam up to 1 per year. • **$40** combined maximum benefit coverage amount per year for routine 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.

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
a Doctor > select the Vision Care icon > select Medicare > select Medicare Advantage.	• **$400** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • **$450** maximum benefit coverage amount per year at PLUS Provider 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. • Maximum benefit coverage amounts cannot be combined. PLUS providers are part of the **Humana Medicare Insight Network** and are indicated in the provider locator search results.	• **$400** 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. • Maximum benefit coverage amounts cannot be combined.
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** or **30%** of the cost
Therapy visits		
• Partial hospitalization	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
SKILLED NURSING FACILITY		
Your plan covers up to 100 days in a SNF	**$0** copay	**$0** or **30%** of the cost for days 1-100

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
PHYSICAL THERAPY		
Comprehensive outpatient rehab facility	**$0** copay	**$0** or **30%** of the cost
Specialist's office	**$0** copay	**$0** or **30%** of the cost
AMBULANCE		
	$0 copay	**$0** or **$300** copay per date of service
TRANSPORTATION		
	$0 copay for plan approved location up to 24 one-way trip(s) per year. This benefit is not to exceed 25 miles per trip. The member *must* contact transportation vendor to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider.	
MEDICARE PART B DRUGS		
Allergy shots and serum		
• Primary care physician's office	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
Chemotherapy drugs at a specialist's office	**$0** copay	**$0** or **30%** of the cost
Other Part B drugs		
• Pharmacy	**$0** copay	**$0** copay
• Primary care physician's office	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost

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.

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Prescription Drug Benefits

PLAN HIGHLIGHTS	
$0 Rx Copay Benefit	If you receive "Extra Help", you will pay **$0** for all Medicare Part D covered prescription drugs on your formulary for the entire calendar year.
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

If you do not receive "Extra Help" refer to Chapter 6 of the Evidence of Coverage for more details on the prescription drug benefit.

To find which pharmacies are available in your network, go to **Humana.com/pharmacyfinder**.

Some drugs are limited to a 30-day supply

Additional Benefits

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
Chiropractic services (Medicare-covered)	**$0** copay	**$0** or **30%** of the cost
Podiatry services (Medicare-covered)	**$0** copay	**$0** or **30%** of the cost
Acupuncture services (Medicare-covered)	**$0** copay	**$0** or **30%** coinsurance for acupuncture for chronic low back pain visits up to 20 visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
MEDICAL EQUIPMENT/SUPPLIES		
Diabetic monitoring supplies		
• Diabetic supplier	**$0** copay	**$0** or **20%** of the cost
• Network retail pharmacy	**$0** copay	**$0** copay
• Preferred diabetic supplier	**$0** copay	**Not Covered**
Durable medical equipment (DME) and related supplies	**$0** copay	**$0** or **30%** of the cost
Medical Supplies at medical supplier	**$0** copay	**$0** or **30%** of the cost

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
Prosthetic devices and related supplies	**$0** copay	**$0** or **30%** of the cost
REHABILITATION SERVICES		
Cardiac rehabilitation services at a specialist's office	**$0** copay	**$0** or **30%** of the cost
Occupational therapy		
• Comprehensive outpatient rehab facility	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
Physical therapy		
• Comprehensive outpatient rehab facility	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
Pulmonary rehabilitation services at a specialist's office	**$0** copay	**$0** or **30%** of the cost
Speech therapy		
• Comprehensive outpatient rehab facility	**$0** copay	**$0** or **30%** of the cost
• Specialist's office	**$0** copay	**$0** or **30%** of the cost
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD) at a specialist's office	**$0** copay	**$0** or **30%** of the cost
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care physician's office	**$0** copay	**Not Covered**
Specialist's office	**$0** copay	**Not Covered**
Substance abuse or behavioral health services	**$0** copay	**Not Covered**
Urgent care services	**$0** copay	**Not Covered**

Medicaid Benefit Comparison

The benefits described in the Covered Medical and Hospital Benefits sections above are covered by HumanaChoice SNP-DE H5970-026 (PPO D-SNP). Below is a comparison of benefits that some Medicaid eligible individuals could receive directly from the New York State Department of Health (SDOH) (Medicaid). For each benefit listed below, you can see what the New York State Department of Health (SDOH) (Medicaid) covers and what our plan covers. All Medicaid benefits are subject to Medicaid eligibility guidelines and requirements and are available only to full dual eligible individuals. If you have questions about your Medicaid eligibility, what benefits you are entitled to, and any cost-sharing you may be responsible for, review your member handbook or contact the New York State Department of Health (SDOH) (Medicaid) at 1-800-541-2831 (toll free).

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Inpatient hospital care	**$25** copay per admit	Covered
Ambulance	Covered	Covered
Ambulatory surgical center	**$3** copay per visit	Covered
Dentures	Covered	Not Covered
Diagnostic services, labs, and imaging	**$0.50** copay per procedure	Covered
Doctor office visits	**$0** copay	Covered
Emergency care	**$3** copay per visit	Covered
Eyeglasses	Covered	Covered
Hearing aids	Covered	Covered
Home and community based waiver service programs	Covered	Not Covered
Inpatient hospital, nursing facility and intermediate care facility services in institutions for mental diseases (MD), age 65 and older	Covered	Covered with limitations
Inpatient psychiatric services, under age 21	Covered	Covered with limitations
Intermediate care facilities for individuals with intellectual disabilities (ICFs-IID)	Covered	Not Covered
Mental health services	Covered	Covered
Nursing facility services, other than in an institution for mental diseases	Covered	Covered with limitations

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Outpatient hospital coverage	Covered	Covered
Physical, occupational, speech therapy	Covered	Covered
Medicare Part B drugs	Covered	Covered
Preventive care	Covered	Covered
Transportation	Covered	Covered
Skilled nursing facility	Covered	Covered
Urgently needed services	Covered	Covered
Durable medical equipment	Covered	Covered
Home health care services	**$0** copay	Covered with limitations
Prosthetic devices	Covered	Covered

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.
This is a summary of what we cover. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of coverage and services. Visit **Humana.com/plandocuments** to view a copy of the EOC or call **1-800-833-2364**.

Healthy Options Allowance

$200 monthly allowance on a prepaid card to use for essentials you need to support your health.

This allowance can be used to buy approved products from participating retail locations (like groceries, over-the-counter health and wellness items, personal care items, home supplies, etc.) or pay for approved services (monthly living expenses like rent, non-medical transportation costs like a taxi, Uber, Lyft, etc.).

Allowance amount cannot be combined with other allowances which may be on the Card.

Unused funds will roll over to the next month and expire at the end of the plan year.

- Allowance is available to use at the beginning of every month.
- Limitations and restrictions may apply.

See the Humana Spending Account Card section for more information.

Humana Spending Account Card

The Humana Spending Account Card is what you use to spend allowances included in this plan. If your previous plan had a Humana Spending Account Card, please keep using the same card. If your previous plan did not have a Humana Spending Account Card, please activate your card as soon as you receive it in the mail.

Please keep this card even after the allowance is spent as future allowance amounts will be added to this card.

- Humana is not responsible for funds lost due to lost or stolen cards.
- Please see the back of your card for more information.
- Allowance amounts cannot be combined with other benefit allowances on the card.
- Limitations and restrictions may apply.

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 Acupuncture

$0 copay for acupuncture visits up to 25 visit(s) per year.

Authorization rules may apply.

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 attempts 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 home delivered meal program for members following an inpatient stay in the hospital or nursing facility.

Post Discharge Personal Home Care
$0 copay for a minimum of 4 hours per day, up to a maximum of 44 hours per year for certain in-home support services following a discharge from a skilled nursing facility or from an inpatient hospitalization.

Qualified aides can offer assistance performing activities of daily living (ADLs) and Instrumental Activities of Daily living (IADLs) within the home.

Activities of daily living are activities related to personal care.

They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.

Instrumental Activities of Daily Living are activities related to independent living.

They include preparing meals, pick up pre-paid curbside/drive-through orders, performing light housework, laundry, dishes, and/or using a telephone.

A member must be receiving assistance with a minimum of one ADL to receive assistance with any IADL.

Services must be initiated within 30 days of discharge event and utilized within 60 days of discharge for each qualifying event up to the maximum annual allowance.

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

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Wigs (related to chemotherapy treatment)
Up to a **$500** combined in and out of network maximum benefit per year.

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, ethnicity, marital status, religion, or language. 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.

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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-320-1235 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-320-1235 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235 (听障专线：711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-320-1235 (聽障專線：711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다 . 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

Form CMS-10802 (Expires 12/31/25) Form Approved OMB# 0938-1421

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بخطتنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-320-1235 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-320-1235 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-320-1235 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

Japanese：当社の健康保険と処方薬プランに関するご質問にお答えするために、無料の通訳サービスをご用意しています。通訳をご用命になるには、1-877-320-1235 (TTY：711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。

Form CMS-10802 (Expires 12/31/25) Form Approved OMB# 0938-1421

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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 12/31/2026 based on a review of Humana's Model of Care.

Your provider may choose to submit to the New York State Department of Health (SDOH) (Medicaid) for consideration of additional secondary payment for an amount applied to deductibles, coinsurance, or copayments. If you are Cost Share Protected, providers are required by federal regulation to accept HumanaChoice SNP-DE H5970-026 (PPO D-SNP) primary payment and the New York State Department of Health (SDOH) (Medicaid) secondary payment as payment in full for covered Medicare Part A and Part B services – even when the Medicaid payment is zero or a provider chooses to not submit to Medicaid.

If you are cost-share protected by the New York State Department of Health (SDOH) (Medicaid), HumanaChoice SNP-DE H5970-026 (PPO D-SNP) providers aren't allowed to collect or bill you for services and items covered under Medicare Part A and Part B, including deductibles, coinsurance, and copayments – even when Medicaid payment is zero or a provider chooses to not submit to Medicaid. If a provider asks you to pay, that's against the law. You may however be responsible for a small Medicaid copayment.

If you are cost-share protected and you are billed or asked to pay the provider for deductibles, coinsurance, or copayments on covered Medicare Part A and Part B services tell your provider you are cost-share protected and can't be charged. If you have already made payment you have the right to a refund. If your provider will not stop billing, you can call us at 1-800-457-4708 or you can call Medicare at 1-800-Medicare (1-800-633-4227), (TTY 1-877-486-2048). Humana or Medicare can ask your provider to stop billing you and refund any payment you have made.

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.

The information you need is just a click away.

Visit Humana.com/PlanDocuments to check details about your plan, including benefits and costs.

If you'd like a printed Evidence of Coverage, Provider Directory, or Drug List mailed to you, you can request one online at the website above, or call **1-800-457-4708 (TTY: 711)**, 24 hours a day, seven days a week. Please have your Humana member ID card ready when you call. When asked for the reason you've called, say "Evidence of Coverage," "Drug List" or "Provider Directory."

Activate your secure MyHumana account.

Your online MyHumana account is an important part of your Humana membership. Use it to view your plan details anytime and access important plan documents online, all in one place. It's easy to use and tailored to you.

Already have an account?

Go to **Humana.com/MyHumanaPlan** and log in.

Don't have an account yet?

Create one using the same link above in just minutes.

Receiving information about other insurance products

As a Humana member, we may call you to offer other insurance-related products. You can opt out of those future calls by calling the Customer Care number on the back of your ID card.

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Humana Inc.
P.O. Box 14168
Lexington, KY 40512-4168

Important information about your plan

Humana.com

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