2027

# Summary of Benefits

## HumanaChoice SNP-DE H7617-038 (PPO D-SNP)

Utah

Select Counties in UT

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H7617_SB_MAPD_PPO_038000_2027_M

Our service area includes the following county/counties in Utah: Beaver, Box Elder, Cache, Davis, Duchesne, Emery, Garfield, Grand, Iron, Juab, Kane, Millard, Morgan, Piute, Rich, Salt Lake, San Juan, Summit, Tooele, Utah, Wasatch, Washington, Weber.

## 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 **888-873-0686 (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 **888-873-0686 (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 (Drug Guide) to make sure your drugs are covered.

### Understanding Important Rules

- [ ] 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 Utah Department of Health and Human Services (Medicaid).
- [ ] Benefits, premiums and/or copays/coinsurance may change on January 1, 2028.
- [ ] **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.
- [ ] This 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 situation, non-contracted providers may deny care. In addition, you may pay a higher copay/coinsurance 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+, SLMB+.

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# Let's talk about HumanaChoice SNP-DE H7617-038 (PPO D-SNP)

Find out more about the HumanaChoice SNP-DE H7617-038 (PPO D-SNP) plan – including the health and drug services it covers – in this easy-to-use booklet.

HumanaChoice SNP-DE H7617-038 (PPO D-SNP) is a Dual Eligible Special Needs plan with a Medicare contract and a contract with Utah Department of Health and Human Services (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/PlanInformation.**

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As a member, it's a good idea to select a doctor as your Primary Care Provider(PCP). HumanaChoice SNP-DE H7617-038 (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

If you receive both Medicare and Medicaid benefits, this means you are dual eligible. To enroll in HumanaChoice SNP-DE H7617-038 (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 Utah Department of Health and Human Services (Medicaid).

HumanaChoice SNP-DE H7617-038 (PPO D-SNP) may enroll FBDE, QMB+, SLMB+.

Full Benefit Dual Eligible (FBDE): May help pay Medicare Part A and/or 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 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.

Specified Low-Income Medicare Beneficiary Plus (SLMB+): Helps pay Part B premiums and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

## Plan name

HumanaChoice SNP-DE H7617-038 (PPO D-SNP)

## More about HumanaChoice SNP-DE H7617-038 (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 Utah Department of Health and Human Services (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 Utah Department of Health and Human Services (Medicaid) for further details.

If you're a member of this plan, call toll free: **800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **888-873-0686 (TTY: 711)**.

You can call us seven days a week from 8 a.m. to 8 p.m. Please note that our automated phone system may answer your call during weekends and holidays.

Or visit our website: **Humana.com/Medicare**

Medicaid benefits last validated on 07/01/2026 and are subject to change. For the most current Utah Medicaid coverage information, please visit Utah Department of Health and Human Services (Medicaid) website at **https://medicaid.utah.gov/** or call the Medicaid Hotline at 800-662-9651 (toll free) 800-346-4128 (TTY).

## A healthy partnership

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

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## Monthly Premium, Deductible and Limits

| | |
|---|---|
| **Monthly plan premium** | **$0**<br>You must keep paying your Medicare Part B premium. Your Part A and/or Part B premium may be paid on your behalf by Utah Department of Health and Human Services (Medicaid) Program. |
| **Medical deductible**<br>* You pay the same amount as you would with Original Medicare. | **$0** or **$283*** combined in-network and out-of-network deductible, depending on your level of Medicaid eligibility. |
| **Pharmacy (Part D) deductible** | If you receive Extra Help, this plan has a **$0** deductible. If you do not receive Extra Help, your plan has a **$600** deductible for Tier 3, Tier 4 and Tier 5 drugs. Refer to the Prescription Drug Benefits section below. |
| **Medical Maximum out-of-pocket responsibility**<br>The most you pay for copays, coinsurance and other costs for covered medical services for the year | **$9,850** in-network<br>**$14,800** combined in- and out-of-network<br>If you are eligible for Medicare cost-sharing assistance under Utah Department of Health and Human Services (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. |

## Medical Benefits

Note: Cost sharing is based on your level of Medicaid eligibility. For this plan, the following Medicaid levels are cost-share protected: FBDE, QMB+ and SLMB+.

| | IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN | OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN |
|---|---|---|
| **INPATIENT HOSPITAL COVERAGE** | | |
| This plan covers an unlimited number of days for an inpatient stay. | **$0** copay | **$0** or **$2,241** copay per admit |
| **OUTPATIENT HOSPITAL COVERAGE** | | |
| **Diagnostic colonoscopy** | **$0** copay | **$0** or **20%** of the cost |
| **Diagnostic mammography** | **$0** copay | **$0** or **20%** of the cost |
| **Surgery services** | **$0** copay | **$0** or **20%** of the cost |
| **AMBULATORY SURGERY CENTER** | | |
| **Diagnostic colonoscopy** | **$0** copay | **$0** or **20%** of the cost |
| **Surgery services** | **$0** copay | **$0** or **20%** of the cost |

*You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization:* ***Humana.com/PAL****.*

## Medical Benefits (cont.)

| | IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN | OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN |
|---|---|---|
| **DOCTOR VISITS** | | |
| **Primary care provider (PCP)** | | |
| • PCP's office | **$0** copay | **$0** or **20%** of the cost |
| • Telehealth | **$0** copay | **Not Covered** |
| **Specialist** | | |
| • Specialist's office | **$0** copay | **$0** or **20%** of the cost |
| • Telehealth | **$0** copay | **Not Covered** |
| **PREVENTIVE CARE** | | |
| This plan covers all Medicare preventive services including:<br>**Cancer Screenings**<br>• Breast cancer screening (mammogram)<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screening<br>• Lung cancer screening<br>• Prostate cancer screening<br><br>**Cardiovascular (heart) Care**<br>• Abdominal aortic aneurysm screening<br>• Cardiovascular disease risk reduction visit<br>• Cardiovascular disease screenings<br><br>**Diabetes Care**<br>• Diabetes screenings<br>• Diabetes self-management training<br>• Medicare Diabetes Prevention Program (MDPP)<br><br>**Dietary Guidance and Support**<br>• Medical nutrition therapy<br>• Obesity screening and therapy | **$0** copay | **$0** copay |

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## Medical Benefits (cont.)

| | IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN | OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN |
|---|---|---|
| **Routine Screenings and Immunizations**<br>• Annual Wellness Visit (AWV)<br>• Immunizations<br>• Routine physical exam<br>• "Welcome to Medicare" preventive visit | | |
| **Screenings and Counseling Services**<br>• Bone mass measurement<br>• Depression screening<br>• Glaucoma screening<br>• HIV screening<br>• Screening & counseling to reduce alcohol misuse<br>• Sexually transmitted infections (STIs) screening and counseling<br>• Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)<br>Any additional preventive services approved by Medicare during the contract year will be covered. | | |
| **EMERGENCY CARE** | | |
| **Emergency room**<br>If you are admitted to the same hospital within 24 hours for the same condition, you pay $0 for the emergency care you received. | **$0** copay | **$0** or **$115** copay |

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## Medical Benefits (cont.)

| | IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN | OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN |
|---|---|---|
| **URGENTLY NEEDED SERVICES** | | |
| • **Telehealth** | **$0** copay | **Not Covered** |
| • **Urgent care center** | **$0** copay | **$0** or **$40** copay |
| Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. | | |
| **WORLDWIDE COVERAGE** | | |
| • **Emergency ambulance** | | **$0** copay |
| • **Emergency room - Hospital** | | **$0** copay |
| • **Urgent care center** | | **$0** copay |
| If you have an emergency or urgently needed service outside of the U.S and its territories, you will be responsible to pay for the rendered services upfront and can request reimbursement. If you are admitted to the same hospital within 24 hours for the same condition, you pay $0 for the emergency care you received. | | |
| **DIAGNOSTIC SERVICES, LABS AND IMAGING** | | |
| **Advanced imaging services (MRI, MRA, PET and CT scans)** | | |
| • Freestanding radiological facility | **$0** copay | **$0** or **$205** copay |
| • Outpatient hospital | **$0** copay | **$0** or **$345** copay |
| • PCP's office | **$0** copay | **$0** or **$330** copay |
| • Specialist's office | **$0** copay | **$0** or **$330** copay |
| **Basic radiological services (X-rays)** | | |
| • Freestanding radiological facility | **$0** copay | **$0** or **20%** of the cost |
| • Outpatient hospital | **$0** copay | **$0** or **20%** of the cost |
| • PCP's office | **$0** copay | **$0** or **20%** of the cost |
| • Specialist's office | **$0** copay | **$0** or **20%** of the cost |
| • Urgent care center | **$0** copay | **$0** or **$40** copay |

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## Medical Benefits (cont.)

| | IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN | OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN |
|---|---|---|
| **Diagnostic mammography** | | |
| • Freestanding radiological facility | **$0** copay | **$0** or **20%** of the cost |
| • Specialist's office | **$0** copay | **$0** or **20%** of the cost |
| **Diagnostic procedures and tests** | | |
| • Outpatient hospital | **$0** copay | **$0** or **20%** of the cost |
| • PCP's office | **$0** copay | **$0** or **20%** of the cost |
| • Specialist's office | **$0** copay | **$0** or **20%** of the cost |
| • Urgent care center | **$0** copay | **$0** or **$40** copay |
| **Lab services** | | |
| • Freestanding laboratory | **$0** copay | **$0** or **20%** of the cost |
| • Outpatient hospital | **$0** copay | **$0** or **20%** of the cost |
| • PCP's office | **$0** copay | **$0** or **20%** of the cost |
| • Specialist's office | **$0** copay | **$0** or **20%** of the cost |
| • Urgent care center | **$0** copay | **$0** or **20%** of the cost |
| **Nuclear medicine and services** | | |
| • Freestanding radiological facility | **$0** copay | **$0** or **20%** of the cost |
| • Outpatient hospital | **$0** copay | **$0** or **20%** of the cost |
| **Sleep study** | | |
| • Member's home | **$0** copay | **$0** copay |
| • Outpatient hospital | **$0** copay | **$0** or **20%** of the cost |
| • Specialist's office | **$0** copay | **$0** or **20%** of the cost |
| **Therapeutic radiology (Radiation therapy)** | | |
| • Freestanding radiological facility | **$0** copay | **$0** or **20%** of the cost |
| • Outpatient hospital | **$0** copay | **$0** or **20%** of the cost |
| • Specialist's office | **$0** copay | **$0** or **20%** of the cost |
| **HEARING SERVICES** | | |
| **Medicare-covered hearing** | **$0** copay | **$0** or **20%** of the cost |
| **Mandatory supplemental hearing benefit** | **HER121**<br>• **$0** copay for routine hearing exams up to 1 per year.<br>• **$0** copay for fitting up to 1 per year. | **HER121**<br>• **95%** of the cost for routine hearing exams up to 1 per year.<br>• **95%** of the cost for fitting up to 1 per year. |

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## Medical Benefits (cont.)

| | IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN | OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN |
|---|---|---|
| | • **$0** copay for follow-up provider visits up to 3 per year.<br>• **$0** copay for each Level 2 prescription hearing aid up to 1 per ear per year.<br>• Note: Includes 3 years of batteries per non-rechargeable aid (up to 60 cells per ear, per year) and 3 year warranty.<br>• One fitting and three follow-up provider visits during first year following hearing aid purchase, with the original provider. | • **95%** of the cost for follow-up provider visits up to 3 per year.<br>• **95%** of the cost for each prescription hearing aid up to 1 per ear per year.<br>• Member is required to pay the full cost at the time of service when utilizing an out-of-network provider.<br>• To receive reimbursement from Humana for eligible items/services, the member must submit required documentation.<br>• Reimbursement will be limited to up to **5%** of the allowed amount on eligible items/services.<br>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |
| **DENTAL SERVICES** | | |
| **Medicare-covered dental** | **$0** copay | **$0** or **20%** of the cost |
| **Mandatory supplemental dental benefit**<br>Limitations and exclusions may apply. Please see your Evidence of Coverage (EOC) for additional details. | **DEN246**<br>• **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.<br>• **$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years.<br>• **$0** copay for bridge recementation, bridges-pontic, complete dentures, crown | **DEN246**<br>• **$0** copay for amalgam and/or composite filling up to 1 per tooth per surface every 2 years.<br>• **$0** copay for crown recementation up to 1 every 2 years.<br>• **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.<br>• **$0** copay for comprehensive oral evaluation or periodontal |

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| | IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN | OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN |
|---|---|---|
| **Benefit Limits**<br>• Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage.<br>• 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.<br>• The member is responsible for any amount above the annual maximum benefit coverage amount.<br>• 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**.<br><br>**In-network providers**<br>• In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS).<br>• If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule (but any applicable coinsurance payment still applies).<br>• Visiting an in-network provider may result in significant savings. The Mandatory | recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years.<br>• **$0** copay for bridges-crown up to 2 every 5 years.<br>• **$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.<br>• **$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.<br>• **$0** copay for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year.<br>• **$0** copay for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.<br>• **$0** copay for periodontal maintenance up to 4 per year.<br>• **$0** copay for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year.<br>• **$1,500** combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits. | exam, occlusal adjustment up to 1 every 3 years.<br>• **$0** copay for crown, denture repair - additions, other restorative services - core buildup and prefabricated post and core up to 1 per tooth every 5 years.<br>• **$0** copay for bridges-pontic, complete dentures, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years.<br>• **$0** copay for bridges-crown up to 2 every 5 years.<br>• **$0** copay per tooth for root canal, root canal retreatment, simple or surgical extraction up to 1 per lifetime.<br>• **$0** copay for necessary nitrous oxide/analgesia with covered service up to 1 unit(s) per visit.<br>• **$0** copay for bitewing x-rays, bridge recementation, denture rebase, denture reline, scaling for moderate inflammation, tissue conditioning up to 1 per year.<br>• **$0** copay for denture repair - broken teeth up to 2 per tooth per year.<br>• **$0** copay for adjustments to dentures, denture repair - base and framework, emergency diagnostic exam, emergency treatment for pain, necessary general anesthesia with covered service, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.<br>• **$0** copay for periodontal maintenance up to 4 per year. |

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| | IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN | OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN |
|---|---|---|
| Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator for our nationwide network can be found at **Humana.com/FindCare**.<br><br>**Out-of-network providers**<br>• Out-of-network dentists have not agreed to provide services at contracted fees.<br>• The out-of-network provider may bill the member for more than what the plan pays, even for services listed with no member cost share. Members are responsible for this difference between Humana's reimbursement and the out-of-network provider's charges. This is known as balance billing.<br>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions.<br>• 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 above for provider locator instructions. Network providers agree to bill us directly.<br>• 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 | | • **$0** copay for intraoral x-rays up to 6 per year.<br>• **$0** copay for necessary incremental anesthesia with covered service up to as needed with covered codes per year.<br>• **$1,500** combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.<br>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |

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## Medical Benefits (cont.)

| | IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN | OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN |
|---|---|---|
| coinsurance level will apply to the average negotiated in-network fee schedule (INFS) in your area.<br>• See Chapter 2 Payment Requests Contact Information in your Evidence of Coverage or visit **Humana.com** for information on requesting reimbursement. | | |
| **VISION SERVICES** | | |
| **Eyewear (post cataract surgery)** | **$0** copay | **$0** copay |
| **Medicare-covered diabetic eye exam** | **$0** copay | **$0** copay |
| **Medicare-covered vision services**<br>The provider locator for Medicare-covered vision can be found at **Humana.com/FindCare**. | **$0** copay | **$0** or **20%** of the cost |
| **Mandatory supplemental vision benefit**<br>Please inform the network provider that you are part of the Humana Medicare Insight Network. NOTE: The network of providers for your supplemental vision benefits through Humana Medicare Insight Network may be different than the network of providers for the Medicare-covered vision benefits. The mandatory supplemental vision benefits are provided through the Humana Medicare Insight Network. The provider locator can be found at **Humana.com/FindCare**. | **VIS694**<br>• **$0** copay for routine exam up to 1 per year.<br>• **$75** combined maximum benefit coverage amount per year for routine exam.<br>• **$50** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.<br>• OR<br>• **$100** maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and | **VIS694**<br>• **$0** copay for routine exam up to 1 per year.<br>• **$75** combined maximum benefit coverage amount per year for routine exam.<br>• **$50** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.<br>• Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. |

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## Medical Benefits (cont.)

| | IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN | OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN |
|---|---|---|
| Benefit is applied toward the retail price. Member is responsible for any costs above the plan approved amount. Lost or broken materials are not covered.<br>This benefit is limited to a one-time use per year. Any remaining benefit dollars do not "roll over" to a future purchase.<br>Eyeglass lens options may be available with the maximum benefit coverage amount up to one pair per year.<br>Benefits are offered on a calendar basis. Any amount unused by the end of the year will expire.<br>Copayments, coinsurances, and deductibles paid for supplemental benefits do not count toward your maximum out-of-pocket amount. | frames, fitting for eyeglasses-lenses and frames.<br>• Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year.<br>• Maximum benefit coverage amount is limited to one time use per year.<br>• Maximum benefit coverage amounts cannot be combined.<br>PLUS providers are part of the Humana Medicare Insight Network and are indicated in the provider locator search results. | • Maximum benefit coverage amount is limited to one time use per year.<br>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.<br>• Maximum benefit coverage amounts cannot be combined. |
| **MENTAL HEALTH SERVICES** | | |
| **Inpatient**<br>This plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital | **$0** copay | **$0** or **$2,091** copay per admit |
| **Mental health therapy visits** | | |
| • Outpatient hospital | **$0** copay | **$0** or **20%** of the cost |
| • Specialist's office | **$0** copay | **$0** or **20%** of the cost |
| • Telehealth | **$0** copay | **Not Covered** |
| **Outpatient substance abuse services** | | |
| • Outpatient hospital | **$0** copay | **$0** or **20%** of the cost |
| • Specialist's office | **$0** copay | **$0** or **20%** of the cost |
| • Telehealth | **$0** copay | **Not Covered** |
| **SKILLED NURSING FACILITY (SNF)** | | |
| This plan covers up to 100 days in a SNF | **$0** copay | **$0** copay per day for days 1-20<br>**$0** or **$221** copay per day for days 21-100 |

*You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization:* ***Humana.com/PAL****.*

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## Medical Benefits (cont.)

| | IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN | OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN |
|---|---|---|
| **AMBULANCE** | | |
| • **Air**<br>• **Ground** | **$0** copay<br>**$0** copay | **$0** or **20%** of the cost<br>**$0** or **$325** copay per date of service |
| **TRANSPORTATION** | | |
| **Mandatory supplemental transportation benefit**<br>The member ***must*** contact transportation vendor at least 3 business days in advance of their appointment to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider. | **$0** copay for plan approved location up to 24 one-way trip(s) per year.<br>This benefit is not to exceed 100 miles per one-way trip. | **95%** coinsurance for plan approved location up to 24 one-way trip(s) per year.<br>This benefit is not to exceed 100 miles per one-way trip.<br>Member is required to pay the full cost at the time of service when utilizing an out-of-network provider.<br>To receive reimbursement from Humana for eligible items/services, the member must submit required documentation.<br>Reimbursement will be limited to up to **5%** of the allowed amount on eligible items/services.<br>Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |

*You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization:* ***Humana.com/PAL****.*

## Medical Benefits (cont.)

| | IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN | OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN |
|---|---|---|
| **Uniformity flexibility non-emergency medical transportation benefit**<br>The member ***must*** contact transportation vendor at least 3 business days in advance of their appointment to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider. | **$0** copayment for plan approved location up to unlimited one-way trip(s) per year for members with a Chronic Kidney Disease (CKD), End Stage Renal Disease (ESRD), or Cancer Diagnosis.<br>This benefit is not to exceed 100 miles per one-way trip. | **95%** coinsurance for plan approved location up to unlimited one-way trip(s) per year for members with a Chronic Kidney Disease (CKD), End Stage Renal Disease (ESRD), or Cancer Diagnosis.<br>This benefit is not to exceed 100 miles per one-way trip.<br>Member is required to pay the full cost at the time of service when utilizing an out-of-network provider.<br>To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to **5%** of the allowed amount on eligible items/services.<br>Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |
| **MEDICARE PART B DRUGS** | | |
| **Allergy shots and serum** | | |
| • PCP's office | **$0** copay | **$0** or **20%** of the cost |
| • Specialist's office | **$0** copay | **$0** or **20%** of the cost |
| **Chemotherapy drugs** | | |
| • Outpatient hospital | **$0** copay | **$0** or **20%** of the cost |
| • Specialist's office | **$0** copay | **$0** or **20%** of the cost |

*You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization:* ***Humana.com/PAL****.*

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## Medical Benefits (cont.)

| | IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN | OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN |
|---|---|---|
| **Other Part B drugs** | | |
| • Outpatient hospital | **$0** copay | **$0** or **20%** of the cost |
| • PCP's office | **$0** copay | **$0** or **20%** of the cost |
| • Pharmacy | **$0** copay | **$0** copay |
| • Specialist's office | **$0** copay | **$0** or **20%** of the cost |
| **Part B Insulin** | | |
| • Outpatient hospital | **$0** copay | **$0** or **20%** of the cost |
| • PCP's office | **$0** copay | **$0** or **20%** of the cost |
| • Pharmacy | **$0** copay | **$0** copay |
| • Specialist's office | **$0** copay | **$0** or **20%** of the cost |

## Prescription Drug Benefits

| PLAN HIGHLIGHTS | |
|---|---|
| **Extra Help** | Most of our members qualify for and are getting Extra Help from Medicare to pay for their prescription drug plan costs. If you are in the Extra Help program, please refer to the Extra Help section below to view your deductible and Initial Coverage Stage cost shares. |
| **100-day supply** | Up to 100-day supply on eligible drugs |
| **Insulin costs** | You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan. |
| **$0 vaccines** | **$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) |

*You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization:* ***Humana.com/PAL****.*

## EXTRA HELP

If you receive Extra Help for your drugs, you will have a **$0** deductible.

Prior to reaching your annual **$2,400** out-of-pocket limit, you will pay one of the following depending on your level of Extra Help:

- **$5.80** for generic/preferred multi-source drug or biosimilar; **$14.40** for any other drug; OR
- **$1.65** for generic/preferred multi-source drug or biosimilar; **$5.00** for any other drug; OR
- **$0** for all drugs

After reaching your annual **$2,400** out-of-pocket limit, you will pay **$0** for the remainder of the calendar year, regardless of the level of Extra Help you receive. Additional information will be available on your LIS rider.

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 800-772-1213 (TTY: 800-325-0778), Monday – Friday, 7 a.m. – 7 p.m. For more information on your prescription drug benefit, please call us or access your Evidence of Coverage online.

## DEDUCTIBLE

This plan has a **$600** deductible for Tier 3, Tier 4 and Tier 5 drugs. You pay the full cost of these drugs until you reach **$600**. Then, you only pay your cost-share, entering into the Initial Coverage Stage.

## INITIAL COVERAGE

You pay the following until your total out-of-pocket costs reach **$2,400**. Once you reach this amount, you will enter the Catastrophic Stage.

**Pharmacy Cost-Sharing**

| | **Retail Cost-Sharing** Includes all in-network retail pharmacies | | **Standard Mail-Order Cost-Sharing** | | **Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy® | |
|---|---|---|---|---|---|---|
| **Day supply** | **30-day** | **100-day*** | **30-day** | **100-day*** | **30-day** | **100-day*** |
| **Tier 1:** Preferred Generic | $0 | $0 | $10 | $30 | $0 | $0 |
| **Tier 2:** Generic | $0 | $0 | $20 | $60 | $0 | $0 |
| **Tier 3:** Preferred Brand | 25% | 25% | 25% | 25% | 25% | 25% |
| **Tier 4:** Non-Preferred Drug | 25% | 25% | 25% | 25% | 25% | 25% |
| **Tier 5:** Specialty Tier | 26% | N/A | 26% | N/A | 26% | N/A |

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

*Some drugs are limited to a 30-day supply and others may be eligible for up to a 100-day supply.

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| Insulin Cost-Sharing | | | | | | |
|---|---|---|---|---|---|---|
| | **Retail Cost-Sharing** Includes all in-network retail pharmacies | | **Standard Mail-Order Cost-Sharing** | | **Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy® | |
| **Day supply** | **30-day** | **100-day*** | **30-day** | **100-day*** | **30-day** | **100-day*** |
| **Tier 1:** Preferred Generic | $0 | $0 | 25% up to $10 | 25% up to $30 | $0 | $0 |
| **Tier 2:** Generic | $0 | $0 | 24% up to $20 | 24% up to $60 | $0 | $0 |
| **Tier 3:** Preferred Brand | 25% up to $35 | 25% up to $105 | 25% up to $35 | 25% up to $105 | 25% up to $35 | 25% up to $105 |
| **Tier 4:** Non-Preferred Drug | 25% up to $35 | 25% up to $105 | 25% up to $35 | 25% up to $105 | 25% up to $35 | 25% up to $105 |
| **Tier 5:** Specialty Tier | 25% up to $35 | N/A | 25% up to $35 | N/A | 25% up to $35 | N/A |

*Not all tiers may include insulin. Please refer to your Prescription Drug Guide to confirm insulin coverage.

You can fill your prescriptions in several ways, including through retail and mail-order pharmacies. For Humana plans, CenterWell Pharmacy® is the preferred mail-order pharmacy with cost-sharing benefits. To learn more, visit **CenterWellPharmacy.com**.

You won't pay more than **$35** for a one-month (up to 30-day) supply of each plan-covered insulin product regardless of cost-sharing tier, even if you haven't paid your deductible.

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

*Some drugs are limited to a 30-day supply and others may be eligible for up to a 100-day supply.

## CATASTROPHIC COVERAGE

After your total out-of-pocket costs reach **$2,400** you pay **$0** for plan-covered Part D drugs.

If you reside at an in-network long-term care facility, you pay the same as you would at an in-network retail pharmacy. Under certain situations you may be able to get drugs from an out-of-network pharmacy but may pay more than you would pay at an in-network pharmacy.

## Additional benefits

| | IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN | OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN |
|---|---|---|
| **Acupuncture services (Medicare-covered)** | **$0** copay for acupuncture for chronic low back pain up to 20 visit(s) per year. | **$0** or **20%** coinsurance for acupuncture for chronic low back pain visits up to 20 visit(s) per year.<br>Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |
| **Chiropractic services (Medicare-covered)** | **$0** copay | **$0** or **20%** of the cost |
| **Podiatry services (Medicare-covered)** | **$0** copay | **$0** or **20%** of the cost |
| **MEDICAL EQUIPMENT/SUPPLIES** | | |
| **Continuous glucose monitor (CGM)** | | |
| • DME provider | **$0** copay | **$0** or **20%** of the cost |
| • Pharmacy | **$0** copay | **$0** copay |
| • Preferred pharmacy | **$0** copay | **Not Covered** |
| **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)** | **$0** copay | **$0** or **20%** of the cost |
| **Medical supplies at medical supplier** | **$0** copay | **$0** or **20%** of the cost |
| **Prosthetic devices and related supplies** | **$0** copay | **$0** or **20%** of the cost |
| **REHABILITATION SERVICES** | | |
| **Cardiac rehabilitation services** | | |
| • Outpatient hospital | **$0** copay | **$0** or **20%** of the cost |
| • Specialist's office | **$0** copay | **$0** or **20%** of the cost |
| **Occupational therapy** | | |
| • Comprehensive outpatient rehab facility | **$0** copay | **$0** or **20%** of the cost |
| • Outpatient hospital | **$0** copay | **$0** or **20%** of the cost |
| • Specialist's office | **$0** copay | **$0** or **20%** of the cost |

*You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization:* ***Humana.com/PAL****.*

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## Additional 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 **20%** of the cost |
| • Outpatient hospital | **$0** copay | **$0** or **20%** of the cost |
| • Specialist's office | **$0** copay | **$0** or **20%** of the cost |
| **Pulmonary rehabilitation services** | | |
| • Outpatient hospital | **$0** copay | **$0** or **20%** of the cost |
| • Specialist's office | **$0** copay | **$0** or **20%** of the cost |
| **Speech therapy** | | |
| • Comprehensive outpatient rehab facility | **$0** copay . | **$0** or **20%** of the cost |
| • Outpatient hospital | **$0** copay | **$0** or **20%** of the cost |
| • Specialist's office | **$0** copay | **$0** or **20%** of the cost |
| **Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)** | | |
| • Outpatient hospital | **$0** copay | **$0** or **20%** of the cost |
| • Specialist's office | **$0** copay | **$0** or **20%** of the cost |

## Medicaid Benefit Comparison

The benefits described in the Covered Medical and Hospital Benefits sections above are covered by HumanaChoice SNP-DE H7617-038 (PPO D-SNP). For each benefit listed below, you can see what Utah Department of Health and Human Services (Medicaid) covers and what this plan covers.

All Medicaid benefits are subject to Utah Department of Health and Human Services (Medicaid) eligibility guidelines and requirements and are available only to full dual eligible individuals. If you have questions about your Medicaid eligibility and what benefits you are entitled to, review your member handbook or contact Utah Department of Health and Human Services (Medicaid) at 800-662-9651 (toll free) 800-346-4128 (TTY).

| BENEFIT | MEDICAID BENEFIT | THIS PLAN BENEFIT |
|---|---|---|
| **Ambulance** | Covered | Covered |
| **Ambulatory surgical center** | Covered | Covered |
| **Dentures** | Covered | Covered |
| **Diagnostic services, labs, and imaging** | Covered | Covered |
| **Doctor visits** | Covered | Covered |

*You do not need a referral to receive covered services from plan providers. This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization:* ***Humana.com/PAL****.*

| BENEFIT | MEDICAID BENEFIT | THIS PLAN BENEFIT |
|---|---|---|
| **Emergency care** | Covered | Covered |
| **Eyeglasses** | Covered | Covered |
| **Hearing aids** | Covered | Covered |
| **Home and community based waiver service programs** | Covered | Not Covered |
| **Inpatient hospital** | Covered | Covered |
| **Inpatient mental health services, nursing facility and intermediate care facility services in institutions for mental diseases (MD), age 65 and older** | Covered | Covered with limitations |
| **Inpatient mental health services, under age 21** | Covered | Covered with limitations |
| **Intermediate care facilities for individuals with intellectual disabilities (ICFs-IID)** | Covered | Not Covered |
| **Medicare Part B drugs** | Covered | Covered |
| **Mental health services** | Covered | Covered |
| **Nursing facility services, other than in an institution for mental diseases** | Covered | Covered with limitations |
| **Outpatient hospital coverage** | Covered | Covered |
| **Physical, occupational, speech therapy** | Covered | Covered |
| **Preventive care** | Covered | Covered |
| **Skilled nursing facility** | Covered | Covered |
| **Transportation** | Covered | Covered |
| **Urgently needed services** | Covered | Covered |

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# More benefits with this plan

Enjoy some of these extra benefits included in this 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/PlanInformation** to view a copy of the EOC or call **888-873-0686**.

**Humana Cell Phone Benefit**
**$0** copayment.

If you are eligible for SSBCI, you MAY receive a cellular phone with unlimited talk, text, and data at no additional cost.

**Humana Healthy Options Allowance®***
**$180** monthly allowance on a prepaid spending card.

All plan members receive this amount to buy approved over the counter (OTC) health and wellness products at participating retailers or through the plan's approved OTC mail order vendor.

Plus, members may also use this money for eligible groceries, utilities, rent, and more if they have certain qualifying chronic condition(s) and meet other program criteria.

Any unused amount rolls over each month and expires at the end of the plan year or upon disenrollment, whichever occurs first.

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

Out-of-network: **95%** coinsurance.
Member is required to pay the full cost at the time of service when utilizing an out-of-network provider.
To receive reimbursement from Humana for eligible items/services, the member must submit required documentation.
Reimbursement will be limited to up to **5%** of the allowed amount on eligible items/services.
Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

**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.

* This spending allowance and Humana Cell Phone Benefit are Special supplemental benefit(s) for members with specific chronic conditions who require intensive care coordination and are at a high risk for hospitalization or other adverse health outcomes. Qualifying conditions may include diabetes mellitus, cardiovascular disorders, chronic and disabling mental health conditions, chronic lung disorders, or chronic heart failure, among others. Some plans require at least two conditions. See the plan's Evidence of Coverage for details. If you use this program for rent or utilities, Housing and Urban Development (HUD) requires it to be reported as income. Contact your local HUD office with questions.

### 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.

**$0** copayment for additional sessions of smoking and tobacco cessation counseling up to 4 per year.

Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

### Humana Well Dine® Meal Program

**$0** copayment for Humana Well Dine® meal program.

After your inpatient stay in either a hospital or a nursing facility, you may be eligible to receive 2 home delivered meals per day for 7 days (up to 14 meals).

Meals must be requested within 30 days of discharge from your inpatient stay.

Limited to 4 times per year.

Out-of-network: You are required to pay the full cost at the time of service when utilizing an out-of-network provider. Humana will reimburse you 5% of the allowed amount on eligible items/services.

To receive reimbursement from Humana for eligible items/services, the member must submit required documentation.

Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

### Rewards and Incentives - Go365® by Humana

Complete eligible healthy activities, like preventive screenings and exams, and get rewarded with Go365 Advanced.

### SilverSneakers® fitness program

**$0** copayment for SilverSneakers®.

The fitness program includes access to participating locations and signature group exercise classes led by certified instructors.

This benefit also connects you to a support network and virtual resources through live classes, on-demand videos and through a mobile app.

Go to SilverSneakers.com to learn more about your benefit.

Out-of-network: **95%** coinsurance for out-of-network fitness centers.

Member is required to pay the full cost at the time of service when utilizing an out-of-network fitness center.

To receive reimbursement from Humana for eligible items/services, the member must submit required documentation.

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Reimbursement will be limited to up to **5%** of the allowed amount on eligible items/services.

Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

# Find out **more**

Need help finding a doctor or pharmacy? You can see this plan's **Provider and Pharmacy Directory** at our website at **Humana.com/FindCare** or call us at the number listed at the beginning of this booklet and we will send you one. Many doctor listings include a Care Highlight® rating. These ratings in clinical quality and cost-efficiency can help you make informed choices about your healthcare. Ratings only appear when we have enough information to measure a doctor's clinical quality and cost-efficiency. Learn more at **Humana.com/CareHighlight**.

You can see this plan's **Drug Guide** at our website at **Humana.com/druglist** or call us at the number listed at the beginning of this booklet and we will send you one.

Clinical quality and cost-efficiency ratings are available in all states except Alaska. Ratings are not available for all physicians. Care Highlight is intended for informational purposes only. Members have access to all physicians in the Humana network, regardless of whether or not the physician has a Care Highlight rating. Ratings should not be the sole basis for selecting a doctor. Humana does not give performance-based payments to doctors based on these ratings. Ratings do not guarantee the quality or outcome of healthcare services.

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.

HumanaChoice SNP-DE H7617-038 (PPO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until December 31, 2028 based on a review of the HumanaChoice SNP-DE H7617-038 (PPO D-SNP) Model of Care.

If you get Medicare cost-share assistance, HumanaChoice SNP-DE H7617-038 (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 billed or asked to pay an in-network 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 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.

Your provider may choose to submit to Utah Department of Health and Human Services (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 H7617-038 (PPO D-SNP) primary payment and Utah Department of Health and Human Services (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.

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 this 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.

All product names, logos, brands and trademarks are property of their respective owners, and any use does not imply endorsement.

## More information is just a click away.

Visit **Humana.com/PlanInformation** to see additional details about this plan, including benefits and costs.

If you'd like a printed Evidence of Coverage, Provider Directory, or Drug Guide mailed to you, you can request one online at the website above, or call **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 Guide" or "Provider Directory."

## Activate your secure MyHumana account.

Your online MyHumana account is an important part of your Humana membership. Use it to view this plan's 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/Member/ManageYourAccount** 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 any future calls using the Customer Care number on the back of your ID card.

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# Notice of Non-Discrimination

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Humana Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).

- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

- U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019, 800-537-7697 (TDD)**

This notice is available at **www.humana.com/legal/non-discrimination-disclosure**.

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# Notice of Availability - Auxiliary Aids and Services Notice

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English: Free language, auxiliary aid, and alternate format services are available. Call **877-320-1235 (TTY: 711)**.

አማርኛ [Amharic]፦ነፃ ቋንቋ፣ አጋዥ ማዳመጫ፣ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችም ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسيق البديل مجاناً. اتصل على الرقم **877-320-1235 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք **877-320-1235 (TTY՝ 711)** հեռախոսահամարով:

Bǎsɔ́ɔ̀ [Bassa]: Wuɖu-xwíníín-mú-zà-zà kǔà, hwòɖǒ-fɔ́nɔ́-nyɔ̀,, kè nyɔ-ɓɔ̌-po-kà ɓě ɓɛ́ wa nyuɛsé wíɖí pɛ́ɛ̀-pɛ́ɛ̀ɖò kɔ. Ɖá **877-320-1235 (TTY: 711)**.

বাংলা [Bengali]: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **877-320-1235 (TTY: 711)** নম্বরে।

简体中文 [Simplified Chinese]：我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 **877-320-1235**（听障专线：**711**）。

繁體中文 [Traditional Chinese]：我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 **877-320-1235**（聽障專線：**711**）。

Kreyòl Ayisyen [Haitian Creole]: Gen sèvis lengwistik gratis, èd oksilyè, ak lòt fòma sèvis ki disponib. Rele **877-320-1235 (TTY: 711).**

Hrvatski [Croatian]: Dostupne su besplatne jezične usluge, usluge dodatne pomoći i alternativnog formata. Nazovite **877-320-1235 (TTY: 711)**.

فارسی [Farsi] : خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **877-320-1235 (TTY: 711)** تماس بگیرید.

Français [French]: Des services gratuits d'assistance linguistique, d'aide auxiliaire et de format alternatif sont disponibles. Appelez le **877-320-1235 (ATS : 711)**.

Deutsch [German]: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **877-320-1235 (TTY: 711)**.

Ελληνικά [Greek]: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **877-320-1235 (TTY: 711)**.

ગુજરાતી [Gujarati] : મફત ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **877-320-1235 (TTY: 711)** પર કૉલ કરો.

עברית [Hebrew]: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **877-320-1235 (TTY: 711)**

हिंदी [Hindi]: निःशुल्क भाषा, सहायक मदद और वैकल्पिक प्रारूप सेवाएं उपलब्ध हैं। **877-320-1235 (TTY:711)** पर कॉल करें।

Hmoob [Hmong]: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **877-320-1235 (TTY: 711)**.

Bekee [Igbo]: Asụsụ n'efu, enyemaka nkwarụ, na ọrụ usoro ndị ọzọ dị. Kpọọ **877-320-1235 (TTY: 711)**.

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Italiano [Italian]: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiamare il numero **877-320-1235 (TTY: 711)**.

日本語 [Japanese]:言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。**877-320-1235 (TTY: 711)** までお電話ください。

ภาษาไทย [Khmer]: សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ ទូរសព្ទទៅលេខ **877-320-1235 (TTY: 711)** ។

한국어 [Korean]: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다. **877-320-1235 (TTY: 711)** 번으로 문의하십시오.

ພາສາລາວ [Lao]: ມີບໍລິການພາສາ, ອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ຮູບແບບທາງເລືອກອື່ນບໍ່ເສຍຄ່າໃຫ້. ໂທ **877-320-1235 (TTY: 711)**.

Diné [Navajo]: Saad bee áná'álwo', bee haz'áanii, dóó naaltsoos t'áá ajiłii'ígíí bee ak'e'elyaaígíí t'áá jiik'eh hólǫ́. **877-320-1235 (TTY: 711)** bich'į' hodíílnih.

नेपाली [Nepali]: निःशुल्क भाषा सेवा, सहायक सामग्री र वैकल्पिक ढाँचाका सेवाहरू उपलब्ध छन् । **877-320-1235 (TTY: 711)** मा कल गर्नुहोस् ।

Polski [Polish]: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **877-320-1235 (TTY: 711)**.

Português [Brazilian Portuguese]: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **877-320-1235 (TTY: 711)**.

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫ਼ਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। **877-320-1235 (TTY: 711)** 'ਤੇ ਕਾਲ ਕਰੋ।

Русский [Russian]: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **877-320-1235 (TTY: 711)**.

Español [Spanish]: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al **877-320-1235 (TTY: 711)**.

Tagalog [Tagalog]: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **877-320-1235 (TTY: 711)**.

தமிழ் [Tamil]: மொழி,, உதவிப் பொருட்கள் மற்றும் மாற்று வடிவமைப்புச் சேவைகள் இலவசமாகக் கிடைக்கின்றன. **877-320-1235 (TTY: 711)** எண்ணை அழைக்கவும்.

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **877-320-1235 (TTY: 711)** కి కాల్ చేయండి.

اردو [Urdu]: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال **877-320-1235 (TTY: 711)**۔

Tiếng Việt [Vietnamese]: Có sẵn miễn phí các dịch vụ ngôn ngữ, hỗ trợ phụ trợ và định dạng thay thế. Hãy gọi **877-320-1235 (TTY: 711)**.

Òyìnbó [Yoruba]: Àwọn iṣẹ́ àtìlẹ́hìn ìrànlọ́wọ́ èdè, àti ọ̀nà kíkà míràn wà lárọ̀wọ́tó lọ́fẹ̀ẹ́. Pe **877-320-1235 (TTY: 711)**.

This notice is available at **https://www.humana.com/legal/multi-language-support**.

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