2019

# Summary of Benefits

## Humana Gold Plus® SNP-DE H4007-018 (HMO SNP)

Puerto Rico
Puerto Rico Island Wide

Our service area is Puerto Rico.

Humana®

## Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-681-3625 (TTY: 711)**.

### Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit **Humana.com/medicare** or call **1-800-681-3625 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

### Understanding Important Rules

- ☐ You do not pay a separate monthly plan premium for this Humana plan but, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2020.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ 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 anyone that is a dual eligible.

2019

# Summary of Benefits

**Humana Gold Plus® SNP-DE H4007-018 (HMO SNP)**
**Platino 100/110/120/130**

Puerto Rico
Puerto Rico Island Wide

Our service area is Puerto Rico.

Humana®

# Let's talk about Humana Gold Plus SNP-DE H4007-018 (HMO SNP)

Find out more about the Humana Gold Plus SNP-DE H4007-018 (HMO SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus SNP-DE H4007-018 (HMO SNP) is a Coordinated Care plan with a Medicare contract and a contract with the Medicaid Program in Puerto Rico. Enrollment in this Humana plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, ask us for the "Evidence of Coverage" or you will receive one after you enroll.

As a member you must select an in-network doctor to act as your Primary Care Provider (PCP). Humana Gold Plus SNP-DE H4007-018 (HMO SNP) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services. 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 Humana Gold Plus SNP-DE H4007-018 (HMO 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 Puerto Rico Medical Assistance program (Medicaid). If you receive both Medicare and Medicaid benefits, this means you are a dual eligible.

Humana Gold Plus SNP-DE H4007-018 (HMO SNP) may enroll anyone that is a dual eligible.

## Plan name:

Humana Gold Plus SNP-DE H4007-018 (HMO SNP)

## More about Humana Gold Plus SNP-DE H4007-018 (HMO SNP)

Depending on your level of eligibility for assistance under your state Medicaid program, you may be subject to cost-sharing for select services. The Comprehensive Benefit Chart shows the benefits you will receive from Humana and how Medicaid covers your cost sharing for those plan benefits. The chart also lists some benefits you could receive from Medicaid if you are eligible for full Medicaid benefits. If you are entitled to Medicaid benefits your care coordinator will work with you to assist you in understanding and accessing the Medicare and Medicaid benefits you may be entitled to.

## 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 your state Medicaid office for further details.

If you're a member of this plan, call toll-free: **1-866-773-5959 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-681-3625 (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 Saturday from 7 a.m. to 6 p.m.

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

For the most current Puerto Rico Medicaid coverage information, please visit the Puerto Rico Medicaid website at https://www.medicaid.pr.gov or call the Medicaid Hotline at **1-787-641-4224 (TTY: 711)**.

## A healthy partnership

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

## Monthly Premium, Deductible and Limits

| | |
|---|---|
| **Monthly plan premium** | **$0**<br>You must keep paying your Medicare Part B premium. The Part B premium may be covered through your State Medicaid Program. |
| **Part B premium reduction** | **$70** |
| **Medical deductible** | This plan does not have a deductible. |
| **Pharmacy (Part D) deductible** | This plan does not have a deductible. |
| **Maximum out-of-pocket responsibility** | **$3,400** in-network<br>The most you pay for copays, coinsurance and other costs for medical services for the year. |

## Covered Medical and Hospital Benefits

**For members protected by the Medicaid Office of Puerto Rico from cost sharing, Medicaid pays coinsurance, copays, and deductibles for Original Medicare covered services.**

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **ACUTE INPATIENT HOSPITAL CARE** | | |
| | **$0** per admit<br><br>Preauthorization required | • For Medicare-covered hospital stays, you pay **$0**, **$4**, **$5** or **$8** copay per admission depending on your coverage code.<br>• Coverage begins on first day of Medicare, and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage, included as covered services on Medicaid state plan. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year). |

*Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." 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 referral and/or prior authorization from the plan.*

# Covered Medical and Hospital Benefits (cont.)

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **OUTPATIENT HOSPITAL COVERAGE** | | |
| **Outpatient surgery at outpatient hospital** | **$0** copay<br><br>Preauthorization required | • **$0**, **$1**, **$1.50** or **$2** copay depending on your coverage code.<br>• Medical and Surgical services not covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.<br>• Voluntary sterilization of men and women of legal age and sound mind, provided that they have been previously informed about the medical procedure's implications, and that there is evidence of Enrollee's written consent by completing the Sterilization Consent Form. |
| **Outpatient surgery at ambulatory surgical center** | **$0** copay<br><br>Preauthorization required | • **$0**, **$1**, **$1.50** or **$2** copay depending on your coverage code.<br>• Medical and Surgical services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.<br>• Voluntary sterilization of men and women of legal age and sound mind, provided that they have been previously informed about the medical procedure's implications, and that there is evidence of Enrollee's written consent by completing the Sterilization Consent Form. |

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# Covered Medical and Hospital Benefits (cont.)

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **DOCTOR OFFICE VISITS** | | |
| **Primary care provider (PCP)** | **$0** copay | • **$0**, **$1**, **$1.50** or **$2** copay for each primary care doctor visit for Medicare-covered benefits, depending on your coverage code.<br>• **$0**, **$1**, **$1.50** or **$2** copay for the cost of each in-area, network urgent care Medicare-covered visit, depending on your coverage code.<br>• **$0**, **$1**, **$1.50** or **$2** copay for each specialist doctor visit for Medicare-covered benefits, depending on your coverage code.<br>• **$0** copay for each Medicare-covered prenatal care doctor visit. |
| **Specialists** | **$0** copay<br><br>Referral required | |
| **PREVENTIVE CARE** | | |
| | **Our plan covers many preventive services at no cost when you see an in-network provider including:**<br>• Abdominal aortic aneurysm screening<br>• Alcohol misuse counseling<br>• Bone mass measurement<br>• Breast cancer screening (mammogram)<br>• Cardiovascular disease (behavioral therapy)<br>• Cardiovascular screenings<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)<br>• Depression screening<br>• Diabetes screenings<br>• HIV screening | Immunization services not covered by:<br><br>1. Medicare Part B<br>2. MAO Part D drug formulary<br>3. MAO supplementary plan benefits<br>4. Not covered by the Puerto Rico Department of Health Immunization Program,<br><br>but included in the Puerto Rico Medicaid State Plan.<br><br>• Vaccines for children from 0-20 years of age:<br>– Hepatitis B<br>– Rotavirus (RV)<br>– DTaP (Diphteria, tetanus and acellular pertussis)<br>– HIB (Hemophilus influenzae type B) |

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# Covered Medical and Hospital Benefits (cont.)

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| | • Medical nutrition therapy services<br>• Obesity screening and counseling<br>• Prostate cancer screenings (PSA)<br>• Sexually transmitted infections screening and counseling<br>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>• Vaccines, including flu shots, hepatitis B shots, pneumococcal shots<br>• "Welcome to Medicare" preventive visit (one-time)<br>• Annual Wellness Visit<br>• Lung cancer screening<br>• Routine physical exam<br>• Medicare diabetes prevention program<br>**Any additional preventive services approved by Medicare during the contract year will be covered.** | – PCV13 and PPSV23 (Pneumococcal conjugate)<br>– Polio (IPV) - Inactivate Polivirus<br>– Influenza vaccine<br>– MMR (Measles, Mumps and Rubella)<br>– Varicella (VAR)<br>– Hepatitis A<br>– Meningococcal Vaccine (HIb-MenCY [MenHibrix], MenACWY-D [Menactra]<br>– Meningococcal ACWY<br>– Meningococcal B<br>– [Bexserol] and Men B- FHbp Trumenba]<br>– Tdap-Tenanus, diphtheria acellular pertusis<br>– Human Papiloma Virus<br>• Vaccines for adults from 21 > 65 years of age:<br>– Influenza<br>– Td /Tdap (Tetanus, diphtheria and acellular pertussis)<br>– Varicella<br>– Human Papiloma Virus<br>– MMR- Measles, Mumps and Rubella<br>– Pneumococcal polysaccharide<br>– Pneumococcal conjugate<br>– Meningococcal<br>– Hepatitis A<br>– Hepatitis B |
| **EMERGENCY CARE** | | |
| **Emergency room**<br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care. | **$0** copay | • **$0** copay for Medicare-covered emergency room visits. |

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# Covered Medical and Hospital Benefits (cont.)

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **Urgently needed services**<br>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. | **$0** copay at an urgent care center | |
| **DIAGNOSTIC SERVICES, LABS AND IMAGING** | | |
| **Diagnostic Mammography** | **$0** copay<br>Preauthorization required | • **$0**, **$0.50**, **$1** or **$1.50** copay, depending on your coverage code, for Medicare-covered:<br>– lab services<br>– diagnostic procedures and tests<br>– X-rays<br>– diagnostic radiology services (not including X-rays)<br>– therapeutic radiology services<br>– Laboratory testing and necessary procedures related to generating a Health Certificate not covered by Medicare or the MAO supplementary benefits but included in the State Plan.<br>• **$0**, **$1**, **$1.50** or **$2** copay, depending on your coverage code, for Medicare-covered:<br>– special diagnostic tests |
| **Diagnostic radiology** | **$0** copay<br>Preauthorization required | |
| **Lab services** | **$0** copay<br>Referral required | |
| **Diagnostic tests and procedures** | **$0** copay<br>Preauthorization and referral required | |
| **Outpatient X-rays** | **$0** copay<br>Preauthorization required | |
| **Radiation Therapy** | **$0** copay<br>Preauthorization required | |

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# Covered Medical and Hospital Benefits (cont.)

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **HEARING SERVICES** | | |
| **Medicare covered hearing** | **$0** copay | Hearing exam **$0**, **$1**, **$1.50** or **$2** copay, depending on your coverage code<br><br>Hearing related services not covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.<br><br>Hearing aids for beneficiaries over 20 years old are excluded from coverage. Refer to ESPDT for hearing cover services. |
| **Routine hearing HER723** | • **$0** copayment for fitting/evaluation, routine hearing exam up to 1 per year.<br>• **$250** maximum benefit coverage amount per ear per year for hearing aids (all types). | |

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# Covered Medical and Hospital Benefits (cont.)

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **DENTAL SERVICES**<br>The cost-share indicated below is what you pay for the covered service. | | |
| **Medicare covered dental** | **$0** copay | Preventive (Child) 100-**$0.00** / 110-**$0.00** /120- **$0.00** /130- **$0.00**<br>Preventive (Adult) 100-**$0.00** / 110-**$1.00** /120- **$1.50** /130- **$2.00**<br>Restorative 100-**$0.00** / 110-**$1.00** /120- **$1.50** /130- **$2.00** |
| **Routine dental DEN158** | • **0%** coinsurance for bitewing x-rays up to 1 set(s) every 2 years.<br>• **0%** coinsurance for amalgam or composite filling up to 1 per tooth every 3 years.<br>• **0%** coinsurance for comprehensive oral exam, panoramic film up to 1 every 3 years.<br>• **0%** coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant per year.<br>• **0%** coinsurance for periodic oral exam, prophylaxis (cleaning) up to 2 per year.<br>• **0%** coinsurance for extractions, root canal up to unlimited per year.<br>• **25%** coinsurance for crown up to 1 per tooth every 5 years.<br>• **25%** coinsurance for complete dentures, partial dentures up to 1 every 5 years.<br>• **25%** coinsurance for adjustments to dentures up to unlimited per year.<br>• **$1000** combined maximum benefit coverage amount per year for adjustments to dentures, complete dentures, crown, partial dentures.<br>**This plan covers additional Platino benefits** | Dental services not covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.<br>The following are the benefits included in the GHP:<br>– All preventive and corrective services for children under age twenty-one (21) mandated by the EPSDT requirement<br>– Pediatric Pulp Therapy (Pulpotomy) for children under age twenty-one (21);<br>– Stainless steel crowns for use in primary teeth following a Pediatric Pulpotomy;<br>– Preventive dental services for Adults;<br>– Restorative dental services for Adults;<br>– One (1) comprehensive oral exam per year;<br>– One (1) periodical exam every six (6) months;<br>– One (1) defined problem-limited oral exam;<br>– One (1) full series of intra oral radiographies, including bite, every three (3) years;<br>– One (1) initial periapical intra-oral radiography; |

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# Covered Medical and Hospital Benefits (cont.)

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| | | – Up to five (5) additional periapical/intra-oral radiographies per year;<br>– One (1) single film-bite radiography per year;<br>– One (1) two-film bite radiography per year;<br>– One (1) panoramic radiography every three (3) years;<br>– One (1) adult cleanse every six (6) months;<br>– One (1) child cleanse every six (6) months;<br>– One (1) topical fluoride application every six (6) months for Enrollees under nineteen (19) years old;<br>– Fissure sealants for life for Enrollees up to fourteen (14) years old (including deciduous molars up to eight (8) years old when medically necessary because of cavity tendencies;<br>– Amalgam restoration;<br>– Resin restorations;<br>– Root canal;<br>– Palliative treatment; and<br>– Oral surgery |
| **VISION SERVICES** | | |
| **Medicare covered vision services** | **$0** copay | Eye Exams **$0**, **$1**, **$1.50** or **$2** copay, depending on your coverage code<br><br>Vision services not covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. |
| **Diabetic eye exam** | **$0** copay | |
| **Glaucoma screening** | **$0** copay | |
| **Eyewear (post-cataract)** | **$0** copay | |

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# Covered Medical and Hospital Benefits (cont.)

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **Routine vision VIS701**<br><br>The provider locator can be found at Humana.com > Find a Doctor > from the Search Type drop down select Vision > Eyemed Access Network. | • **$0** copayment for routine exam, refraction up to 1 per year.<br>• **$400** maximum benefit coverage amount per year for contact lenses or eyeglasses - lenses and frames (includes fitting). Eyeglasses will include ultraviolet protection and scratch resistant coating. | Eyeglasses or lenses for beneficiaries between the ages of 0-20 years when **medically necessary** will be covered, the benefit of eyeglasses and lenses consist of single or multifocal lens and a standard frame eyeglass every 24 months. All types of lenses have to be pre authorized except intraocular lenses. Repair or replacement of eyeglasses within 24 months when this is medically necessary and approved by the pre authorization will be covered. |
| **MENTAL HEALTH SERVICES** | | |
| **Inpatient**<br>Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital | **$0** per admit<br><br>Preauthorization required | • For Medicare-covered hospital stays, you pay **$0**, **$4**, **$5** or **$8** copay per admission, depending on your coverage code.<br>• Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage, included as covered services on Medicaid state plan. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year). |
| **Outpatient group and individual therapy visits** | **$0** copay<br><br>Preauthorization and referral required | |
| **SKILLED NURSING FACILITY (SNF)** | | |
| Your plan covers up to 100 days in a SNF | **$0** per admit<br><br>Preauthorization required | |

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## Covered Medical and Hospital Benefits (cont.)

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **PHYSICAL THERAPY** | | |
| | **$0** copay<br><br>Preauthorization and referral required | • **$0**, **$1**, **$1.50** or **$2** copay for Medicare-covered Physical and/or Speech/Language Therapy visits, depending on your coverage code<br>• Covered without limits under Medicare Part B (Medical Insurance). Do not apply within Wrap-Around. |
| **AMBULANCE** | | |
| **Ambulance (ground)** | **$0** per date of service<br><br>Preauthorization required for non-emergency | |
| **TRANSPORTATION** | | |
| | **$0** copay for up to 8 one-way trips to plan approved locations<br><br>The member *must* contact transportation vendor to arrange transportation.<br><br>Preauthorization required | |

## Prescription Drug Benefits

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **MEDICARE PART B DRUGS** | | |
| **Chemotherapy drugs** | **$0** copay<br><br>Preauthorization required | |
| **Other part B drugs** | **$0** copay<br><br>Preauthorization required | |

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| PRESCRIPTION DRUGS | | |
|---|---|---|
| **Medicare Part D Drugs** | See chart below for plan coverage information for prescription drugs | Medicaid may cover some drugs that are not covered by Part D. Contact your Medicaid agency for questions on drug coverage.<br><br>For coverage code 100<br>Preferred (children 0-20) **$0**<br>Preferred (adult) **$0**<br>Non-Preferred (children 0-20) **$0**<br>Non-Preferred (adult) **$0**<br>Outpatient Substance Abuse **$0**<br><br>For coverage code 110<br>Preferred (children 0-20) **$0**<br>Preferred (adult) **$1**<br>Non-Preferred (children 0-20) **$0**<br>Non-Preferred (adult) **$3**<br>Outpatient Substance Abuse **$0**<br><br>For coverage code 120<br>Preferred (children 0-20) **$0**<br>Preferred (adult) **$2**<br>Non-Preferred (children 0-20) **$0**<br>Non-Preferred (adult) **$4**<br>Outpatient Substance Abuse **$0**<br><br>For coverage codes 130<br>Preferred (children 0-20) **$0**<br>Preferred (adult) **$3**<br>Non-Preferred (children 0-20) **$0**<br>Non-Preferred (adult) **$6**<br>Outpatient Substance Abuse **$0**<br><br>• Prescription drugs not covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.<br>• Any cost sharing not included on the MAO benefit design as approved by CMS, including deductible, coinsurance or coverage gaps exceeding the State plan.<br>• The drug needs to be in the GHP formulary and needs to be subject to the applicable edits as established in the GHP Formulary of Medications in |

Coverage (FMC). It also needs to comply with the following:

- All MAOs pharmacy benefit will provide full year drug coverage with their CMS approved Part D Drugs Formulary, and subject to established Platino copayments as the only out of pocket contribution.
- Drugs not included in the MAOs Part D Drugs Formulary should undergo CMS required exception process for possible approval of non-covered drugs. If exception process denial is sustained by the MAOs, including the appeal process, but if the drug is covered by the GHP Formulary of Medications in Coverage (FMC), the drug will be covered under the Wrap-Around. The prescriber physician needs to exhaust available MAO formulary on the needed drug category.
- Prescription drugs that do not appear on the Contractor's Medicare Part D formulary and are not covered under the exception process shall be covered under the Platino benefit if it is listed as a covered drug under the GHP Formulary. Drugs in the GHP Formulary shall be covered under the Platino benefit under the applicable therapeutic class.

**Pharmacy (Part D) Deductible**

**Deductible** This plan does not have a deductible.

**Initial coverage**

You pay the following until your total yearly drug costs reach **$3,820**. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.

## Standard cost-sharing

| Pharmacy options | Retail To find the retail pharmacies near you, go to Humana.com/pharmacyfinder | | Mail order Humana Pharmacy®, Walmart Mail | |
|---|---|---|---|---|
| | 30-day supply | 90-day supply | 30-day supply | 90-day supply |
| **Tier 1:** Preferred Generic | $0 | $0 | $0 | $0 |
| **Tier 2:** Generic | $0 | $0 | $0 | $0 |
| **Tier 3:** Preferred Brand | $0 | $0 | $0 | $0 |
| **Tier 4:** Non-Preferred Drug | $0 | $0 | $0 | $0 |
| **Tier 5:** Specialty Tier | $0 | N/A | $0 | N/A |

Generic drugs may be covered on tiers other than Tier 1 and Tier 2 so please check this plan's Humana Drug List to validate the specific tier on which your drugs are covered.

Specialty drugs are limited to a 30 day supply.

Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for "Extra Help." For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our "Evidence of Coverage" online.

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

You may get drugs from an out-of-network pharmacy but may pay more than you pay at an in-network pharmacy.

**Days' Supply Available**
Unless otherwise specified, you can get your Part D drug in the following days' supply amounts:
- One month supply (up to 30 days)*
- Two month supply (31-60 days)
- Three month supply (61-90 days)

*Long term care pharmacy (one month supply = 31 days)

## Coverage Gap

Under this plan, you may pay even less for the following:

**Tier 1** (Preferred Generic) - All Drugs

**Tier 2** (Generic) - All Drugs

**Tier 3** (Preferred Brand) - All Drugs

**Tier 4** (Non-Preferred Drug) - All Drugs

**Tier 5** (Specialty Tier) - All Drugs

For more information on cost sharing in the coverage gap, please call us or access our Evidence of Coverage online.

**Catastrophic Coverage**

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$5,100**, your share of the cost for a covered drug will be:

- **$0** copay for all drugs

## Additional benefits

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **Medicare-covered foot care (podiatry)** | **$0** copay | |
| **Medicare-covered chiropractic services** | **$0** copay | |
| **MEDICAL EQUIPMENT/SUPPLIES** | | |
| **Durable medical equipment (like wheelchairs or oxygen)** | **$0** copay<br>Preauthorization required | |
| **Medical Supplies** | **$0** copay<br>Preauthorization required | |
| **Prosthetics (artificial limbs or braces)** | **$0** copay<br>Preauthorization required | |
| **Diabetic monitoring supplies** | **$0** copay | |
| **REHABILITATION SERVICES** | | |
| **Physical, occupational and speech therapy** | **$0** copay<br>Preauthorization and referral required | • **$0**, **$1**, **$1.50** or **$2** copay for Medicare-covered Physical and/or Speech/Language Therapy visits, depending on your coverage code<br>• Covered without limits under Medicare Part B (Medical Insurance). Do not apply within Wrap-Around. |
| **Cardiac rehabilitation** | **$0** copay<br>Preauthorization required | |
| **Pulmonary rehabilitation** | **$0** copay<br>Preauthorization required | |

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **Inpatient substance abuse** | **$0** copay<br><br>Preauthorization required | **$0**, **$4**, **$5** or **$8** copay for Inpatient substances abuse depending on your coverage code<br><br>Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage, included as covered services on Medicaid state plan. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year). |
| **Outpatient substance abuse** | **$0** copay<br><br>Preauthorization and referral required | **$0**, **$1**, **$1.50** or **$2** copay for Outpatient substance abuse depending on your coverage code<br><br>Coverage begins on first day of Medicare, and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage, included as covered services on Medicaid state plan. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year). |
| **Outpatient mental healthcare and professional services** | **$0** copay<br><br>Preauthorization and referral required | **$0**, **$1**, **$1.50** or **$2** copay for Outpatient mental healthcare and professional services depending on your coverage code<br><br>All mental health related OPD services and twenty-four (24) hours a day, seven (7) days a week emergency and crisis intervention non-covered by Medicare or the MAO supplementary benefits but included in the State Plan. |

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **EPSDT under 21 years** | **$0** copay | **$0** copay for EPSDT services<br><br>EPSDT requirements non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.<br><br>EPSDT Checkups must include all of the following:<br>A comprehensive health and developmental history; Developmental assessment, including mental, emotional, and Behavioral Health development; Measurements (including head circumference for infants); An assessment of nutritional status; A comprehensive unclothed physical exam; Immunizations according to the guidance issued by the Advisory Committee on Immunization Practices (ACIP) (the vaccines themselves are provided and paid for by the Health Department for the Medicaid and CHIP Eligible. Certain laboratory tests; Anticipatory guidance and health education; Vision screening; Tuberculosis; Hearing screening; and Dental and oral health assessment.<br>(Reference must be made to the corresponding CMS EPSDT guidelines and ASES policy). |
| **Family planning** | **$0** copay | **$0** copay for Family Planning<br><br>Family Planning services not covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.<br><br>Puerto Rico Medicaid benefits provide reproductive health and family planning counseling. Such services shall be provided voluntarily and confidentially, including circumstances where |

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| | | the beneficiary is under age eighteen (18). Family planning services will include, at a minimum, the following: education and counseling; pregnancy testing; infertility assessment; sterilization services in accordance with 42 CFR 441.200 subpart F; laboratory services; cost and insertion/removal of non-oral products, such as long acting reversible contraceptives (LARC); at least one of every class and category of FDA-approved contraceptive; at least one of every class and category of FDA-approved contraceptive method; and other FDA approved contraceptive medications or methods when it is Medically Necessary and approved through a Prior Authorization or through an exception process and the prescribing Provider can demonstrate at least one of the following situations:<br>• Contra-indication with drugs that the Enrollee is already taking, and no other methods covered/available that can be used by the Enrollee.<br>• History of adverse reaction by the Enrollee to the contraceptive methods covered.<br>• History of adverse reaction by the Enrollee to the contraceptive medications that are covered. |
| **Tobacco cessation** | **$0** copay | **$0** copay for tobacco cessation<br><br>Tobacco cessation services not covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. |

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **Maternity services** | **$0** copay | **$0** copay for maternity services<br><br>Maternity services not covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.<br><br>Abortions when the pregnancy is a result of rape or incest as certified by a physician. |
| **Special Coverage** | **$0** copay | **$0**, **$1**, **$1.50** or **$2** copay for special coverage depending on your coverage code.<br><br>The conditions ASES classifies as special coverage and that do not require referral:<br>– HIV/AIDS<br>– Tuberculosis<br>– Leprosy<br>– Lupus<br>– Cystic Fibrosis<br>– Cancer<br>– Hemophilia<br>– ESRD => Levels 3, 4, and 5<br>– Parkinson<br>– Multiple Sclerosis<br>– Scleroderma<br>– Pulmonary Hypertension<br><br>Treatment, as well as related services, for the abovementioned special conditions do not need a referral from the Primary Care Physician (PCP) once the diagnosis has been established. |
| **Physical Exam** | **$0** copay | **$0**, **$1**, **$1.50** or **$2** copay for a physical exam depending on your coverage code |

# Additional Medicaid Covered Services

Dual eligible members who meet financial criteria for full Medicaid coverage may also be eligible to receive all Medicaid services not covered by Medicare. Humana Gold Plus may also offer coverage for these services. The benefits described below are covered by Medicaid. The benefits described in the Covered Medical and Hospital Benefits section of the Summary of Benefits are covered by Medicare. For each benefit listed below, you can see what the Government Health Plan (or "the GHP") Medicaid Program covers and what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility. If you have questions about your Medicaid eligibility and what benefits you are entitled to call: 1-787-641-4224 (TTY: 711).

| BENEFIT | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID STATE PLAN |
|---|---|---|
| **PRODUCTS AND DEVICES** | | |
| **Dentures** | See "Dental" benefit in the "Covered Medical and Hospital Benefits" chart above | Not covered |
| **Eyeglasses** | See "Vision" benefit in the "Covered Medical and Hospital Benefits" chart above | Glasses or lenses for beneficiaries between the ages of 0-20 years when medically necessary will be covered, the benefit of eyeglasses and lens consist of a single or multifocal lens and a standard frame eyeglasses every 24 months. |
| **Hearing Aids** | See "Hearing" benefit in the "Covered Medical and Hospital Benefits" chart above | Not covered |

**HOME AND COMMUNITY BASED WAIVER SERVICES PUERTO RICO**
This plan does not provide waivers for home and community-based services.

The Additional Medicaid Covered Services table above reflects Medicaid services available on a fee for service basis for dual eligibles who meet the eligibility requirements for full Medicaid benefits. All references to age 0-20 represents 0-20 (inclusive).

The Medicaid information included in this section was verified by ASES and is current as of 7/1/2018. All Medicaid covered services are subject to change at any time. For the most current Puerto Rico Medicaid coverage information, please visit the Puerto Rico Medicaid website at www.medicaid.pr.gov or call the Medicaid Hotline at **1-787-641-4224 (TTY: 711)**.

# More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

**Smoking cessation program**
To further assist in your effort to quit smoking or tobacco product use, we cover one additional counseling quit attempt within a 12-month period as a service with no cost to you. This is in addition to the two counseling attempt provided by Medicare and includes up to four face-to-face visits. This service can be used for either preventive measures or for diagnosis with a tobacco related disease.

**Bathroom safety device**
A device like a chair or bench for the tub or shower can help prevent injuries in the bathroom. You may receive one bathroom safety device every five years.

**Blood pressure monitor**
Pay **$0** copay for a blood pressure monitor every five years.

**Enhanced Nutrition Therapy**
Additional one-on-one nutrition therapy counseling.

**Well Dine Meal Program**
Humana's meal program for members following an inpatient stay in the hospital or nursing facility

**HumanaPrimero Nurse Hotline**
Health advice from a registered nurse, available 24 hours a day, seven days a week.

**Over-the-Counter (OTC) mail order**
Up to **$30** allowance every 3 months for the purchase of OTC supplies from Humana Pharmacy mail delivery.

**Wigs (related to chemotherapy treatment)**
Up to a **$500** maximum benefit per year.

**Humana Rewards**
Rewards for completing certain preventive health screenings and health and wellness activities.

**SilverSneakers® fitness program**
Basic fitness center membership including fitness classes.

# Find out **more**

You can see our plan's **provider and pharmacy directory** at our website at **www.humana.com/members/tools** 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 list** at our website at **www.humana.com/medicare/medicare_prescription_drugs/medicare_drug_tools/medicare_drug_list/** or call us at the number listed at the beginning of this booklet and we will send you one.

This information is not a complete description of benefits. Call 1-866-773-5959 (TTY: 711) for more information.

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.

**This information is available in a different format**, including Braille, large print, and audio tapes. Please call Customer Care at the number listed in the beginning of this document if you need plan information in another format.
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-681-3625 (TTY: 711).

Humana has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2019 based on a review of Humana's Model of Care.

The provider/pharmacy network may change at any time. You will receive notice when necessary.

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# Notes

# Notes

## Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion.

Humana Inc. and its subsidiaries provide: (1) 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; and, (2) free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call **1-877-320-1235** or if you use a **TTY**, call **711**.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion, you can file a grievance with 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 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, 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**.

## Multi-Language Interpreter Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-877-320-1235 **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-1235 **(TTY: 711)** 注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。 請致電 1-877-320-1235 **(TTY : 711)**。 ... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-320-1235 **(TTY: 711)**.... 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-877-320-1235 **(TTY: 711)** 번으로 전화해 주십시오 .... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-320-1235 **(TTY: 711)**.... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-320-1235 **(телетайп: 711)**.... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-320-1235 **(TTY: 711)**.... ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-320-1235 **(ATS: 711)**.... UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-320-1235 **(TTY: 711)**.... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-320-1235 **(TTY: 711)**.... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-320-1235 **(TTY: 711)**.... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-320-1235 **(TTY: 711)**.... 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-877-320-1235 **(TTY: 711)** まで、お電話にてご連絡ください。...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-320-1235 تماس بگیرید. **(TTY: 711)**

**Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih** 1-877-320-1235 **(TTY: 711)**....

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-320-1235 **(رقم هاتف الصم والبكم: 711)**.

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