2019

# Summary of Benefits

## Humana Gold Plus® SNP-DE H5619-075 (HMO SNP)

Central Kentucky
Central Kentucky Area

Our service area includes the following county/counties in Kentucky: Bourbon, Bullitt, Clark, Fayette, Hardin, Jefferson, Jessamine, Madison, Montgomery, Oldham, Scott, Woodford.

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## Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-833-2364 (TTY: 711)**.

### Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit **Humana.com/medicare** or call **1-800-833-2364 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

### Understanding Important Rules

- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 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 dual eligibles who are QMB Plus and QMB.

2019

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# Let's talk about Humana Gold Plus SNP-DE H5619-075 (HMO SNP)

Find out more about the Humana Gold Plus SNP-DE H5619-075 (HMO SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus SNP-DE H5619-075 (HMO SNP) is a Coordinated Care plan with a Medicare contract and a contract with the Kentucky Department of Medicaid Services 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, 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 H5619-075 (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 H5619-075 (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 Kentucky Medical Assistance program (Medicaid). If you receive both Medicare and Medicaid benefits, this means you are a dual eligible.

Humana Gold Plus SNP-DE H5619-075 (HMO SNP) may enroll dual eligibles who are QMB Plus and QMB.

## Plan name:

Humana Gold Plus SNP-DE H5619-075 (HMO SNP)

## More about Humana Gold Plus SNP-DE H5619-075 (HMO SNP)

As a member of this plan, you will not be responsible for cost sharing for plan benefits. The Comprehensive Benefit Chart shows the benefits you will receive from Humana and how Medicaid covers your cost sharing for those plan benefits. The chart also lists some benefits you could receive from Medicaid if you are eligible for full Medicaid benefits. If you are entitled to Medicaid benefits your care coordinator will work with you to assist you in understanding and accessing the Medicare and Medicaid benefits you may be entitled to.
Be sure to show your Medicaid ID card in addition to your Humana membership card to make your provider aware that you may have additional coverage. Your services are paid first by Humana and then by Medicaid.

## How to reach us:

If you have questions about your benefits or your level of eligibility for assistance from Medicaid, you should contact Humana's Customer Care department or your state Medicaid office for further details.

If you're a member of this plan, call toll-free: **1-800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-833-2364 (TTY: 711)**.

**October 1 - March 31:**
Call 7 days a week from 8 a.m. - 8 p.m.

**April 1 - September 30:**
Call Monday - Friday, 8 a.m. - 8 p.m.

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

For the most current Kentucky Medicaid coverage information, please visit the Kentucky Medicaid website at http://chfs.ky.gov/dms/ or call the Medicaid Hotline at **1-800-635-2570 (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. |
| **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** | This plan does not have a maximum out-of-pocket responsibility. |

## Covered Medical and Hospital Benefits

**For members protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copays and deductibles for Original Medicare covered services. For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.**

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **ACUTE INPATIENT HOSPITAL CARE** | | |
| | **$0** copay | **$50** per admission for Medicaid-covered services. |
| **OUTPATIENT HOSPITAL COVERAGE** | | |
| **Outpatient surgery at outpatient hospital** | **$0** copay | • **$4** copay for Medicaid-covered services. |
| **Outpatient surgery at ambulatory surgical center** | **$0** copay | • Ambulatory Surgery Center (ASC) - **$4** per visit |
| **DOCTOR OFFICE VISITS** | | |
| **Primary care provider (PCP)** | **$0** copay | **$3** copay for Medicaid-covered services |
| **Specialists** | **$0** copay | **$3** copay for Medicaid-covered services |
| **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) | **$0** copay for Medicaid-covered services.<br><br>**Bone Mass Measurement**<br>(for people with Medicare who are at risk) |

*You do not need a referral to receive covered services from providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.*

# Covered Medical and Hospital Benefits (cont.)

**WHAT YOU PAY ON THIS HUMANA PLAN**

- Cardiovascular disease (behavioral therapy)
- Cardiovascular screenings
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screening
- Diabetes screenings
- HIV screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screening and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, including flu shots, hepatitis B shots, pneumococcal shots
- "Welcome to Medicare" preventive visit (one-time)
- Annual Wellness Visit
- Lung cancer screening
- Routine physical exam
- Medicare diabetes prevention program

**Any additional preventive services approved by Medicare during the contract year will be covered.**

**MEDICAID USUAL LIMITS AND COPAYS**

**Colorectal Screening Exams**
(for people with Medicare age 50 and older)

**Immunizations**
(Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)

**Mammograms (Annual Screening)**
(for women with Medicare age 40 and older)

**Pap Smears and Pelvic Exams**
(for women with Medicare)

**Prostate Cancer Screening Exams**
(for men with Medicare age 50 and older)

**Welcome to Medicare; and Annual Wellness Visit**

**Health/Wellness Education**

- Written health education materials, including Newsletters
- Nutritional Training
- Additional Smoking Cessation
- Other Wellness Benefits

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# Covered Medical and Hospital Benefits (cont.)

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **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 per visit<br>• **$8** copay per visit will be imposed if the condition is not an emergency |
| **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 | **$3** copay for Medicaid-covered services. |
| **DIAGNOSTIC SERVICES, LABS AND IMAGING** | | |
| **Diagnostic Mammography** | **$0** copay | Laboratory Services - **$3** copay per visit<br>Radiology Services - **$3** copay per visit |
| **Diagnostic radiology** | **$0** copay | |
| **Lab services** | **$0** copay | |
| **Diagnostic tests and procedures** | **$0** copay | |
| **Outpatient X-rays** | **$0** copay | |
| **Radiation Therapy** | **$0** copay | |

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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 | Copays are **$0** unless otherwise noted.<br><br>**Includes but not limited to:**<br>Assessment for hearing aid/instrument; fitting; orientation; and repair, modification and checking hearing aid/instrument<br>Not to exceed $800 per ear every 36 months<br><br>**Audiometric Services Children under 21 - Includes but not limited to:**<br>Complete hearing evaluation and hearing instrument evaluation<br>One (1) audiologist visit per calendar year<br><br>**Not covered for Adults 21 and older**<br>Hearing Aid /instrument<br>Audiometric services |
| **Routine hearing HER945** | • **$0** copayment for routine hearing exams up to 1 per year.<br>• **$0** copayment for fitting/evaluation up to 3 per year.<br>• **$0** copayment for advanced level hearing aid purchase up to 1 per ear per year.<br>• Note: Includes 48 batteries per aid and 3 year warranty.<br>TruHearing provider must be used. | |
| **DENTAL SERVICES**<br>The cost-share indicated below is what you pay for the covered service. | | |
| **Medicare covered dental** | **$0** copay | Services include but not limited to exams, cleanings, x-rays, fillings, extractions, oral surgery and emergency dental treatment<br><br>**Dental Services Children under 21**<br>Unless provider demonstrates that dental services in excess of the following limits are medically necessary, the limits are:<br>• 1 Oral exam per 12 month period<br>• 2 cleanings per 12 month period<br>• 1 set of x-rays per 12 month period |

*You do not need a referral to receive covered services from providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.*

# Covered Medical and Hospital Benefits (cont.)

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| | | • Other dental services are available<br><br>Dental Services Adults 21 and older<br>**$3** copay per visit<br>• 1 dental visit per month per provider<br>• 1 oral exam per 12-month period<br>• 1 cleaning per 12-month period<br>• 1 set of X-rays per 12-month period<br>• Extractions and Fillings if medically necessary<br><br>**Not Covered:**<br>Dentures for adults<br>Braces for teeth, dentures, partials, and bridges for adults 21 and older |
| **Routine dental DEN176**<br><br>Use the HumanaDental Medicare network for the Mandatory Supplemental Dental. The provider locator can be found at Humana.com > Find a Doctor > from the Search Type drop down select Dental > under Coverage Type select All Dental Networks > enter zip code > from the network drop down select HumanaDental Medicare. | • **$0** copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.<br>• **$0** copayment for periodontal exam up to 1 every 3 years.<br>• **$0** copayment for complete, partial dentures up to 1 set every 5 years.<br>• **$0** copayment for panoramic film or diagnostic x-rays, recementation up to 1 every 5 years.<br>• **$0** copayment for bitewing x-rays up to 1 set per year.<br>• **$0** copayment for adjustments to dentures, denture reline, intraoral x-rays, root canal up to 1 per year.<br>• **$0** copayment for amalgam and/or composite filling, crown, emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, comprehensive oral evaluation, | |

*You do not need a referral to receive covered services from providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.*

# Covered Medical and Hospital Benefits (cont.)

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| | and/or emergency diagnostic exam, periodontal maintenance, prophylaxis (cleaning), simple or surgical extraction up to 2 per year.<br>• **$0** copayment for necessary anesthesia with covered service up to unlimited per year.<br>• **$2000** maximum benefit coverage amount per year. | |
| **VISION SERVICES** | | |
| **Medicare covered vision services** | **$0** copay | **Children under 21**<br>Covered services include exams and prescription eyewear.<br>1 pair per year and an extra pair if the original pair is lost or broken or the prescription changes<br>• 1 exam per calendar year<br>• Eye glasses: **$0** copay per visit<br>**Vision Services Adults 21 and older**<br>Covered services include:<br>• 1 eye exam per calendar year<br>• **$3** per visit |
| **Diabetic eye exam** | **$0** copay | |
| **Glaucoma screening** | **$0** copay | |
| **Eyewear (post-cataract)** | **$0** copay | |
| **Routine vision VIS733**<br><br>The provider locator can be found at Humana.com > Find a Doctor > from the Search Type drop down select Vision > Eyemed Select Network. | • **$0** copayment for routine exam, refraction up to 1 per year.<br>• **$300** 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. | |

*You do not need a referral to receive covered services from providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.*

# Covered Medical and Hospital Benefits (cont.)

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **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** copay | • **$0** copay for Medicaid-covered services.<br><br>Mental Health:<br>**Psychotherapy:** Individual, Family, and Group Psychotherapy sessions.<br>**Group therapy:** Maximum number of members is 12 per group and a maximum of 3 hours of therapy per day.<br>**Individual therapy:** limit to maximum of 3 hours of therapy per day<br>Therapeutic Rehabilitation Services CMHC -<br>• **$0** copay per visit<br><br>Substance Abuse:<br>Chemical and alcohol dependency and/or abuse treatment.<br>• **$0** copay for Medicaid-covered services. |
| **Outpatient group and individual therapy visits** | **$0** copay | |
| **SKILLED NURSING FACILITY (SNF)** | | |
| Your plan covers up to 100 days in a SNF | **$0** copay | Facility services are only covered for individuals with intellectual disabilities or a developmental disability for both the categorically needy and medically needy members.<br>• **$0** copay for Medicaid-covered services. |
| **PHYSICAL THERAPY** | | |
| | **$0** copay | • Physical Therapy - **$3** copay per visit at an approved setting |
| **AMBULANCE** | | |
| **Ambulance (ground)** | **$0** copay | • **$0** copay for Medicaid-covered services |

*You do not need a referral to receive covered services from providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.*

## Covered Medical and Hospital Benefits (cont.)

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **TRANSPORTATION** | | |
| | **$0** for up to unlimited one-way trips to plan approved locations. Not to exceed 25 miles per trip. The member *must* contact transportation vendor to arrange transportation. | Non-Emergent Transportation (NET) - **$0** copay for Medicaid-covered services |

## Prescription Drug Benefits

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **MEDICARE PART B DRUGS** | | |
| **Chemotherapy drugs** | **$0** copay | For members protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copays and deductibles for Medicare Part B Drugs. |
| **Other part B drugs** | **$0** copay | |
| **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. For Medicaid covered drugs the following copays apply:<br>• **$1** copay for generic<br>• **$4** copay preferred brand<br>• **$8** Non-preferred brand<br><br>**Members age 18 and under:** unlimited<br><br>**Member age 19 and older following limits apply:**<br>• Generic drugs: limited to 4 prescriptions a month<br>• Brand drugs: maximum of 3 per month (insulin is excluded from the limit) |

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

*You do not need a referral to receive covered services from providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.*

Depending on the level of Extra Help you receive, you'll pay one of the following cost-share amounts each time you fill your drug. You will always pay **$0** for Tier 1 drugs on this plan at a Preferred Cost-Sharing Retail or Preferred Cost-Sharing Mail Order Pharmacy.

| **Pharmacy options** | | |
|---|---|---|
| **Preferred cost-sharing** | **Mail order:** Humana Pharmacy®<br>**Retail:** To find the preferred cost-share retail pharmacies near you, go to **Humana.com/pharmacyfinder** | |
| **Standard cost-sharing** | **Mail order:** Walmart Mail<br>**Retail:** All other network retail pharmacies | |
| **For generic drugs** (including brand drugs treated as generic), either: | **30-day supply** | **90-day supply** |
| | **$0** copay; or<br>**$1.25** copay; or<br>**$3.40** copay; | **$0** copay; or<br>**$1.25** copay; or<br>**$3.40** copay; |
| **For all other drugs**, either: | **$0** copay; or<br>**$3.80** copay; or<br>**$8.50** copay; | **$0** copay; or<br>**$3.80** copay; or<br>**$8.50** copay; |

Specialty drugs are limited to a 30 day supply.

Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 Monday — Friday, 7 a.m. — 7 p.m. TTY users should call 1-800-325-0778. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access 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)

## Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$5,100**, you pay nothing for all drugs.

# Additional benefits

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **Medicare-covered foot care (podiatry)** | **$0** copay | • **$3** copay for Medicaid-covered services. |
| **Medicare-covered chiropractic services** | **$0** copay | • **$3** copay per visit for Medicaid-covered services<br>• 26 visits per 12 month period |
| **MEDICAL EQUIPMENT/SUPPLIES** | | |
| **Durable medical equipment (like wheelchairs or oxygen)** | **$0** copay | Durable Medical Equipment:<br>• **$4** copay per date of service.<br>Includes but not limited to items such as medical supplies diabetic supplies (lancets, glucose testing strips), nebulizers, infusion pumps, wheelchairs and hospital beds.<br><br>**Not covered:**<br>Devices and equipment that are primarily and customarily used for non-medical purposes are not covered. Some items include: comfort or convenience items, physical fitness equipment, and safety alarms and alert systems. |
| **Medical Supplies** | **$0** copay | |
| **Prosthetics (artificial limbs or braces)** | **$0** copay | Prosthetics:<br>Includes but not limited to such items as leg, arm and neck braces, diabetic and custom molded shoes, artificial limbs, breast prostheses, and prosthetic eyes.<br><br>• **$4** copay for Medicaid-covered services |
| **Diabetic monitoring supplies** | **$0** copay | Diabetic Supplies and Services<br>• **$0** copay for Medicaid-covered services<br>• **$4** copay per date of service |

| | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID USUAL LIMITS AND COPAYS |
|---|---|---|
| **REHABILITATION SERVICES** | | |
| **Physical, occupational and speech therapy** | **$0** copay | • Physical Therapy - **$3** copay per visit at an approved setting<br>• Occupational Therapy - **$3** copay per visit at an approved setting<br>• Speech Therapy - **$3** copay per visit at an approved setting |
| **Cardiac rehabilitation** | **$0** copay | |
| **Pulmonary rehabilitation** | **$0** copay | |

## Additional Medicaid Covered Services

Dual eligible members who meet financial criteria for full Medicaid coverage may also be eligible to receive all Medicaid services not covered by Medicare. 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 Kentucky Department of Medicaid Services 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: 1-800-635-2570 (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 | • Adults 21 and older - not covered. |
| **Eyeglasses** | See “Vision” benefit in the “Covered Medical and Hospital Benefits” chart above | • Adults 21 and older - not covered. |
| **Hearing Aids** | See “Hearing” benefit in the “Covered Medical and Hospital Benefits” chart above | • Adults 21 and older - not covered. |
| **TRANSPORTATION** | | |
| **Non-Emergency Medical Transportation Services** | See “Transportation” benefit in the “Covered Medical and Hospital Benefits” chart above | • **$0** copay<br>• Unlimited transportation only to KY Medicaid approved medical services. |

| | | |
|---|---|---|
| **INPATIENT LONG TERM CARE SERVICES** | | |
| **Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services in Institutions for Mental Diseases (IMD), age 65 and older** | Not covered | • **$0** copay during Medicare covered days, Cost Share for Medicaid only days are based on Post Eligibility Treatment of Income rules. |
| **Inpatient Psychiatric Services, under age 21** | See “Mental Health” benefit in the “Covered Medical and Hospital Benefits” chart above | • **$0** copay during Medicare covered days, Cost Share for Medicaid only days are based on Post Eligibility Treatment of Income rules. |
| **Intermediate Care Facility Services for Individuals with Intellectual Disabilities** | Not Covered | • **$0** copay during Medicare covered days, Cost Share for Medicaid only days are based on Post Eligibility Treatment of Income rules. |
| **Nursing Facility Services, other than in an Institution for Mental Diseases** | See “Skilled Nursing” benefit in the “Covered Medical and Hospital Benefits” chart above | • **$0** copay during Medicare covered days, Cost Share for Medicaid only days are based on Post Eligibility Treatment of Income rules. |
| **Other Medicaid Covered Services** | | |
| **Private Duty Nursing** | Not Covered | • **$0** copay<br>• 2,000 hours per year |
| **Cardiac and Pulmonary Rehabilitation Services** | Not Covered | **Covered if medically necessary** for dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. |
| **Family Planning** | Not Covered | Services shall be provided through routine physician visits or through family planning clinics Includes complete medical history, physical examination, medical services, laboratory and clinical test supplies, educational material, counseling and prescribed birth control methods to best suit the patient's needs. Family planning services shall be made available to all persons of child bearing age who desire the services and supplies<br><br>**$0** copay |

| | | |
|---|---|---|
| **Labor/Delivery** | Not Covered | Alternative Birthing Center - **$0** per visit<br>Prenatal visits as appropriate; labor and Delivery services which includes necessary supplies and material; and the post-delivery examination; post-natal visits; and Laboratory services as specified by the Cabinet for Health and Family Services. Post-natal visits, not to exceed two (2) and which shall be accomplished within six (6) weeks of the delivery. |

| | | |
|---|---|---|
| **Sterilizations and Hysterectomies** | Not Covered | Tubal Ligation is covered for mentally competent, female members 21 years of age and older. Members must provide their physician with informed consent form (MAP-250) 30 to 180 days prior to the date of sterilization. In the case of a premature delivery the informed consent must have been given at least 30 days before expected due date and at least 72 hours must pass, since consent was signed for both premature delivery and/or emergency abdominal surgery.<br><br>**Hysterectomy Adults 21 and older** - Member must be at least 21 years of age, mentally competent, voluntarily gives informed consent after being informed that the procedure will cause the member to be permanently incapable of reproducing, interpreter provided when language barrier exist, and not institutionalized in a correctional facility, mental hospital or other rehabilitative facility. Covered if procedure performed for medical necessity and MAP-251 (Patient's Acknowledgement of Prior Receipt of Hysterectomy Information Form) must be signed and dated prior to the Hysterectomy.<br><br>Not covered if performed for hygienic reasons or for sterilization only.<br><br>Not covered for mentally incompetent or institutionalized member |

| | | |
|---|---|---|
| **Renal Dialysis** | **$0** copay | • **$0** copay for Medicaid-covered services.<br>• Dialysis services include those services and procedures designed to promote and maintain the functioning of the kidney and related organs. Could be inpatient dialysis, outpatient dialysis, self-dialysis and home dialysis. |
| **Hospice** | **You pay nothing** for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details. | Available to members certified as being terminally ill and having a medical prognosis life expectancy of six (6) months or less.<br>• **$0** copay for Medicaid-covered services |

**HOME AND COMMUNITY BASED WAIVER SERVICES**

Dual eligible members, who meet the financial criteria for full Medicaid coverage, may also be eligible to receive Waiver services. Waiver services are limited to individuals who meet additional waiver eligibility criteria. For information on waiver services and eligibility, contact Medicaid at 1-800-635-2570 (TTY: 711).

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.

The Medicaid information included in this section is current as of 7/1/2018. All Medicaid-covered services are subject to change at any time. For the most current Kentucky Medicaid coverage information, please visit the Kentucky Medicaid website at http://chfs.ky.gov/dms/ or call the Medicaid Hotline at **1-800-635-2570 (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.

**Chiropractic services**
Routine chiropractic:
**$0** copay per visit for up to 12 visits

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

**Routine foot care**
**$0** copay per visit for up to 6 visits

**Well Dine Meal Program**
Humana's meal program for members with certain special needs plan (SNP) specific conditions or following an inpatient stay in the hospital or nursing facility

**HumanaFirst® 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 **$175** allowance every 3 months for the purchase of OTC supplies from Humana Pharmacy mail delivery.

**Virtual Visits - Medical**
Access to doctors and other practitioners via phone and/or video technology for diagnosis and treatment of certain non-emergency medical issues.

You pay a **$0** copay to receive a remote medical consultation.

**Virtual Visits – Mental and Behavioral Health**
Access to doctors and other mental health professionals via phone and/or video technology for diagnosis and treatment of certain non-emergency mental or behavioral issues.

You pay a **$0** copay to receive a remote mental and behavioral consultation.

**Wigs (related to chemotherapy treatment)**
Up to an unlimited maximum benefit per year.

**Go365™ by Humana**
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 1-800-457-4708 (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 1-800-833-2364 (TTY: 711).

Humana has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2020 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.

Limitations on healthcare and prescription services delivered via virtual visits and communications options vary by state. Virtual visit services are not a substitute for emergency care and not intended to replace your primary care provider or other providers in your network. This material is provided for informational use only and should not be construed as medical advice or used in place of consulting a licensed medical professional.

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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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Central Kentucky Area

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