2022

Summary of Benefits

Humana Gold Plus SNP-DE H5619-038 (HMO D-SNP)

Northern/Central California
Select Counties in California

Our service area includes the following county/counties in California: Fresno, Kern, Kings, Madera, San Joaquin, San Luis Obispo, Stanislaus, Tulare, Ventura.

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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, 2023.
- ☐ 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 SLMB Plus, QMB Plus and FBDE.

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Let's talk about Humana Gold Plus SNP-DE H5619-038 (HMO D-SNP)

Find out more about the Humana Gold Plus SNP-DE H5619-038 (HMO D-SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus SNP-DE H5619-038 (HMO D-SNP) is a Coordinated Care plan with a Medicare contract and a contract with Medi-Cal (Medicaid). Enrollment in this Humana plan depends on contract renewal.

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

As a member you must select an in-network doctor to act as your Primary Care Provider (PCP). Humana Gold Plus SNP-DE H5619-038 (HMO D-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 H5619-038 (HMO 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 Medi-Cal (Medicaid). If you receive both Medicare and Medicaid benefits, this means you are a dual eligible.

Humana Gold Plus SNP-DE H5619-038 (HMO D-SNP) may enroll dual eligibles who are SLMB Plus, QMB Plus and FBDE.

Plan name:

Humana Gold Plus SNP-DE H5619-038 (HMO D-SNP)

More about Humana Gold Plus SNP-DE H5619-038 (HMO D-SNP)

As a member of this plan, you will not be responsible for cost sharing for plan benefits. The Comprehensive Benefit Chart shows the benefits you will receive from Humana and how Medicaid covers your cost sharing for those plan benefits. The chart also lists some benefits you could receive from Medicaid if you are eligible for full Medicaid benefits. If you are entitled to Medicaid benefits your care coordinator will work with you to assist you in understanding and accessing the Medicare and Medicaid benefits you may be entitled to.
Be sure to show Medi-Cal (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 Medi-Cal (Medicaid) for further details.

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

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

October 1 - March 31:

Call 7 days a week from 8 a.m. - 8 p.m.

April 1 - September 30:

Call Monday - Friday, 8 a.m. - 8 p.m.

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

For the most current California Medicaid coverage information, please visit Medi-Cal (Medicaid) website at **http://www.medi-cal.ca.gov/** or call the Medicaid Hotline at 1-800-400-0815 (TTY: 711).

A healthy partnership

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

Monthly Premium, Deductible and Limits

Monthly plan premium	**$0** You must keep paying your Medicare Part B premium. The Part B premium may be covered through the California 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 Benefit

For members protected by Medi-Cal (Medicaid) Program from cost sharing, Medicaid pays coinsurance, copays and deductibles for Original Medicare-covered services. You may be required to pay a Medicaid copay.

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
ACUTE INPATIENT HOSPITAL CARE		
	$0 copay	
OUTPATIENT HOSPITAL COVERAGE		
Outpatient surgery at outpatient hospital	**$0** copay	
Outpatient surgery at ambulatory surgical center	**$0** copay	
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	
Specialists	**$0** copay	
PREVENTIVE CARE		
	Our plan covers many preventive services at no cost when you see an in-network provider including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings	

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.

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
	• 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.	
EMERGENCY CARE		
Emergency room If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	**$0** copay	

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 Benefit (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$0** copay	
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic mammography	**$0** copay	
Diagnostic radiology	**$0** copay	
Lab services	**$0** copay	
Diagnostic tests and procedures	**$0** copay	
Outpatient X-rays	**$0** copay	
Radiation therapy	**$0** copay	
HEARING SERVICES		
Medicare-covered hearing	**$0** copay	
Routine hearing	In-network: **HER865** • **$0** copayment for fitting/evaluation, routine hearing exams up to 1 per year. • **$1000** maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per 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 Benefit (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
DENTAL SERVICES The cost-share indicated below is what you pay for the covered service.		
Medicare-covered dental	**$0** copay	Dental services are covered for adults when provided in an FQHC or RHC • Optional benefits coverage is limited to only beneficiaries in "Exempt Groups": 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program 2) beneficiaries residing in a SNF (Nursing Facilities Level A and Level B, including subacute care facilities) 3) beneficiaries who are pregnant 4) CCS beneficiaries 5) beneficiaries enrolled in the PACE
Routine dental Dental benefits may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**. Use the HumanaDental Medicare network for the Mandatory Supplemental Dental. The provider locator can be found at **Humana.com** > Find a Doctor > from the Search Type drop down select Dental > under Coverage Type select All Dental Networks > enter zip code > from the network drop down select HumanaDental Medicare.	In-network: **DEN338** • **0%** coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **0%** coinsurance for comprehensive oral evaluation or periodontal exam, scaling for moderate inflammation up to 1 every 3 years. • **0%** coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years. • **0%** coinsurance for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • **0%** coinsurance for emergency diagnostic exam up to 1 per year. • **0%** coinsurance for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **0%** coinsurance for periodontal maintenance up to 4 per year. • **0%** coinsurance for amalgam and/or composite filling, necessary anesthesia with covered service up to unlimited per year. • **$2000** maximum benefit coverage amount per year for preventive and comprehensive benefits.	

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 Benefit (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
VISION SERVICES		
Medicare-covered vision services	**$0** copay	Covers eye examinations and prescriptions for corrective lenses. Further services are not covered. • Optional benefits coverage is limited to only beneficiaries in "Exempt Groups": 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program 2) beneficiaries residing in a SNF (Nursing Facilities Level A and Level B, including subacute care facilities) 3) beneficiaries who are pregnant 4) CCS beneficiaries 5) beneficiaries enrolled in the PACE
Medicare-covered diabetic eye exam	**$0** copay	
Medicare-covered glaucoma screening	**$0** copay	
Medicare-covered eyewear (post-cataract)	**$0** copay	
Routine vision Refraction is only covered when billed as part of the routine vision exam. The provider locator for routine vision can be found at **Humana.com** > Find a Doctor > select Vision care icon > Vision coverage through Medicare Advantage plans.	In-network: **VIS733** • **$0** copayment for routine exam up to 1 per year. • **$300** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year.	
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$0** copay	
Outpatient group and individual therapy visits	**$0** copay	
SKILLED NURSING FACILITY (SNF)		
Your plan covers up to 100 days in a SNF	**$0** copay	

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 Benefit (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
PHYSICAL THERAPY		
	$0 copay	Physical therapy and occupational therapy services are covered when provided by persons who meet the appropriate requirements
AMBULANCE		
Ambulance	**$0** copay	
TRANSPORTATION		
	$0 copay for plan approved location up to 24 one-way trip(s) per year. This benefit is not to exceed 50 miles per trip. The member *must* contact transportation vendor to arrange transportation.	

Prescription Drug Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
MEDICARE PART B DRUGS		
Chemotherapy drugs	**$0** copay	
Other Part B drugs	**$0** copay	
PRESCRIPTION DRUGS		
Medicare Part D Drugs	See chart below for plan coverage information for prescription drugs	**$1** copay** • Medicaid may cover some drugs that are not covered by Part D. Contact Medi-Cal (Medicaid) agency for questions on drug coverage.

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.

Deductible This plan does not have a deductible.

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® **Retail:** To find the preferred cost-share retail pharmacies near you, go to **Humana.com/pharmacyfinder**	
Standard cost-sharing	**Mail order:** Walmart Mail **Retail:** All other network retail pharmacies	
For generic drugs (including brand drugs treated as generic), either:	**30-day supply** **$0** copay; or **$1.35** copay; or **$3.95** copay; or **15%** of the cost	**90-day supply** **$0** copay; or **$1.35** copay; or **$3.95** copay; or **15%** of the cost
For all other drugs, either:	**$0** copay; or **$4** copay; or **$9.85** copay; or **15%** of the cost	**$0** copay; or **$4** copay; or **$9.85** copay; or **15%** of the cost

Other pharmacies are available in our network.

Specialty drugs are limited to a 30-day supply.

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

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

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

Days' Supply Available

Unless otherwise specified, you can get your Part D drug in the following days' supply amounts:

- One-month supply (up to 30 days)*
- Two-month supply (31-60 days)
- Three-month supply (61-90 days)

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

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,050**, you pay nothing for all drugs.

Additional Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
Medicare-covered foot care (podiatry)	**$0** copay	
Medicare-covered chiropractic services	**$0** copay	Chiropractic services are covered with other services at a maximum of two services per month. The other services that contribute to the maximum are acupuncture, audiology, occupational therapy, podiatry, and speech therapy. • Services are limited to the treatment of the spine by means of manual manipulation • Optional benefits coverage is limited to only beneficiaries in "Exempt Groups": 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program 2) beneficiaries residing in a SNF (Nursing Facilities Level A and Level B, including subacute care facilities) 3) beneficiaries who are pregnant 4) CCS beneficiaries 5) beneficiaries enrolled in the PACE
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**$0** copay	
Medical Supplies	**$0** copay	
Prosthetics (artificial limbs or braces)	**$0** copay	
Diabetic monitoring supplies	**$0** copay	

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
REHABILITATION SERVICES		
Occupational and speech therapy	**$0** copay	Physical therapy and occupational therapy services are covered when provided by persons who meet the appropriate requirements Speech therapy services are covered with other services at a maximum of two services per month. The other services that contribute to the maximum are acupuncture, audiology, chiropractic, podiatry, and occupational therapy. • Speech Therapy services are covered with other services at a maximum of two services per beneficiaries under 21 years of age for services rendered pursuant to EPSDT program; 2) beneficiaries residing in a SNF (Nursing Facilities Level A and Level B, including subacute care facilities) or in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD), including Intermediate Care Facility for the Developmentally Disabled/Habilitative (ICF/DD-H) and Intermediate Care Facility for the Developmentally Disabled/Nursing (ICF/DD-N); 3) beneficiaries who are pregnant; 4) CCS beneficiaries; and 5) beneficiaries enrolled in the PACE.
Cardiac rehabilitation	**$0** copay	
Pulmonary rehabilitation	**$0** copay	
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	
Specialist	**$0** copay	
Urgent care services	**$0** copay	

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
Substance abuse or behavioral health services	**$0** copay	

Additional Medicaid Covered Services

Dual eligible members who meet financial criteria for full Medicaid coverage may also be eligible to receive all Medicaid services not covered by Medicare. Humana Gold Plus SNP-DE H5619-038 (HMO D-SNP) may also offer coverage for these services. The benefits described in the Covered Medical and Hospital Benefits section of the Summary of Benefits are covered by Medicare. The benefits described below are covered by Medicaid. For each benefit listed below, you can see what Medi-Cal (Medicaid) covers and what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility. If you have questions about your Medicaid eligibility and what benefits you are entitled to call Medi-Cal (Medicaid): 1-800-400-0815 (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	Optional benefits coverage is limited to only beneficiaries in "Exempt Groups": 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program 2) beneficiaries residing in a SNF (Nursing Facilities Level A and Level B, including subacute care facilities) 3) beneficiaries who are pregnant 4) CCS beneficiaries 5) beneficiaries enrolled in the PACE
Eyeglasses	See "Vision" benefit in the "Covered Medical and Hospital Benefits" chart above	Eye appliances are covered on the written prescription of a physician or optometrist • Optional benefits coverage is limited to only beneficiaries in "Exempt Groups": 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program 2) beneficiaries residing in a SNF (Nursing Facilities Level A and Level B, including subacute care facilities)

		3) beneficiaries who are pregnant 4) CCS beneficiaries 5) beneficiaries enrolled in the PACE
Hearing Aids	See "Hearing" benefit in the "Covered Medical and Hospital Benefits" chart above	Hearing aids are covered only when supplied by a hearing aid dispenser or prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available in the community, plus an audiological evaluation including a hearing aid evaluation which must be performed by or under the supervision of the above physician or by a licensed audiologist
TRANSPORTATION		
Non-Emergency Medical Transportation Services	See "Transportation" benefit in the "Covered Medical and Hospital Benefits" chart above	Non-emergency medical transportation necessary to obtain medical services is covered subject to the written prescription of a physician, dentist or podiatrist
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	Authorization is required
Inpatient Psychiatric Services, under age 21	See "Mental Health" benefit in the "Covered Medical and Hospital Benefits" chart above	Authorization is required

Intermediate Care Facility Services for Individuals with Intellectual Disabilities	Not Covered	**$0** copay • Intermediate care facility services for the developmentally disabled are covered subject to prior authorization by the Department. Authorizations must be requested in advance. Plans of care must be reviewed every 90 days. The attending physician shall sign the authorization request and shall certify to the Department that the beneficiary requires this level of care. Acute administrative days are covered, when authorized by a Medi-Cal (Medicaid) consultant subject to the acute inpatient facility has made appropriate and timely discharge planning, all other coverage has been utilized and the acute inpatient facility meets the requirements contained in the Manual of Criteria for Medi-Cal (Medicaid) Authorization.
Nursing Facility Services, other than in an Institution for Mental Diseases	See "Skilled Nursing" benefit in the "Covered Medical and Hospital Benefits" chart above	Skilled Nursing facility services are covered subject to prior authorization by the Department. Authorizations must be requested in advance. Plans of care must be reviewed every 60 days. The attending physician shall sign the authorization request and shall certify to the Department that the beneficiary requires this level of care.

Other Medicaid Covered Services		
Acupuncture	See "Acupuncture" benefit on the "More benefits with your plan" page later in this document if covered by plan.	Acupuncture services shall be limited to treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition Two services per month Must be provided by a physician, dentist, podiatrist or certified acupuncturist enrolled in the Medi-Cal (Medicaid) program and who is eligible to provide Medi-Cal (Medicaid) services
Renal Dialysis	**$0** copay	Procedure used to treat kidney failure - covered only as an outpatient service

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 Medi-Cal (Medicaid) at 1-800-400-0815 (TTY: 711).

**Exemptions. The following categories of recipients are not required to pay a copayment or coinsurance:

(a) Individuals under the age of 21 years.
(b) Pregnant women – for pregnancy – related services, including services for medical conditions that may complicate the pregnancy. This exemption includes the six week period following the end of the pregnancy.
(c) Individuals receiving services in an inpatient hospital setting, long-term care facility, or other medical institution if, as a condition of receiving services in the institution, that individual is required to spend all of his or her income for medical care costs with the exception of the minimal amount required for personal needs.
(d) Individuals who require emergency services after the sudden onset of a medical condition which, if left untreated, would place their health in serious jeopardy.
(e) Individuals receiving services or supplies related to family planning.

The Additional Medicaid Covered Services table above reflects services available on a fee for service basis for dual eligibles who meet the eligibility requirements for full Medicaid benefits.

The Medicaid information included in this section is current as of 7/1/2021. All Medicaid covered services are subject to change at any time. For the most current California Medicaid coverage information, please visit Medi-Cal (Medicaid) website at **http://www.medi-cal.ca.gov/** or call the Medicaid Hotline at 1-800-400-0815 (TTY: 711).

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

COVID-19 Testing and Treatment

$0 copay for testing and treatment services for COVID-19.

Healthy Foods Card

$35 automatically loaded every month to spend at participating retailers toward the purchase of approved healthy foods.

Chiropractic services

Routine chiropractic:
$0 copay per visit for up to 12 visits.

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.

Routine foot care

$0 copay per visit for up to 12 visits.

Humana Well Dine® Meal Program

Humana's meal program for members following an inpatient stay in the hospital or nursing facility.

Over-the-Counter (OTC) mail order

$125 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products.

Personal Emergency Response System

The personal emergency response system provides help in emergency situations. GoSafe Mobile personal help button functions both in and out of the home. GoSafe uses two way voice communication & five location seeking technologies to send help quickly to wherever the member is located.

Rewards and Incentives

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

Wigs (related to chemotherapy treatment)

Up to a **$500** maximum benefit per year.

SilverSneakers® fitness program

Basic fitness center membership including fitness classes.

Find out **more**

You can see our plan's **provider and pharmacy directory** at our website at **humana.com/finder/search** or call us at the number listed at the beginning of this booklet and we will send you one.

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

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

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

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

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

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

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

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Humana.com

Important!

At Humana, it is important you are treated fairly.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

فارسی (Farsi)

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

Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę́ niká'adoowoł.

العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

Humana Gold Plus SNP-DE H5619-038
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