2023

Summary of Benefits

Humana Gold Plus SNP-DE H4007-019 (HMO D-SNP)

Puerto Rico
Puerto Rico Island Wide

Our service area is Puerto Rico.

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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 **1-800-681-3625 (TTY: 711)**.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **Humana.com/medicare** or call **1-800-681-3625 (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.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- ☐ 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.

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Let's talk about Humana Gold Plus SNP-DE H4007-019 (HMO D-SNP)

Find out more about the Humana Gold Plus SNP-DE H4007-019 (HMO D-SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus SNP-DE H4007-019 (HMO D-SNP) is a Coordinated Care plan HMO with a Medicare contract and a contract with the Administración de Seguros de Salud (ASES) (Medicaid) program. Enrollment in this Humana plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, 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 H4007-019 (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. Please contact your provider(s) to verify that they have registered with Puerto Rico Medicaid. 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 H4007-019 (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 the Administración de Seguros de Salud (ASES) (Medicaid). If you receive both Medicare and Medicaid benefits, this means you are dual eligible.

Plan name:

Humana Gold Plus SNP-DE H4007-019 (HMO D-SNP)

More about Humana Gold Plus SNP-DE H4007-019 (HMO D-SNP)

You are responsible for cost sharing on this plan. The Covered Medical and Hospital Benefits chart shows the benefits you will receive from Humana.

Be sure to show the Administración de Seguros de Salud (ASES) (Medicaid) ID card in addition to your Humana membership card to make your provider aware that you also have Medicaid coverage.

How to reach us:

If you have questions about your benefits or your level of eligibility for assistance from Medicaid, you should contact Humana's Customer Care department or the Administración de Seguros de Salud (ASES) (Medicaid) 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**.

Medicaid benefits last validated on 07/01/2022 and are subject to change.

For the most current Puerto Rico Medicaid coverage information, please visit the Administración de Seguros de Salud (ASES) (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** You must keep paying your Medicare Part B premium.
Part B premium reduction	Your plan will reduce your Monthly Part B premium by up to **$105**
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 The most you pay for copays, coinsurance and other costs for covered medical services for the year.

Covered Medical and Hospital Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN
ACUTE INPATIENT HOSPITAL CARE	
	$0 copay per admit
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 • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening

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.

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Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
	• 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
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 at an urgent care center
DIAGNOSTIC SERVICES, LABS AND IMAGING	
Diagnostic mammography	**$0** copay
Diagnostic colonoscopy	**$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	

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Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
	HER045 • **$0** copay for fitting/evaluation, routine hearing exams up to 1 per year. • **$2000** maximum benefit coverage amount for hearing aids (all types) up to 2 per year.
DENTAL SERVICES	
Medicare-covered dental	**$0** copay
Routine dental Dental benefits may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**.	**DEN522** • **0%** of the cost for bitewing x-rays up to 1 set(s) every 2 years. • **0%** of the cost for amalgam or composite filling up to 1 per tooth every 3 years. • **0%** of the cost for comprehensive oral exam, panoramic film up to 1 every 3 years. • **0%** of the cost for crown up to 1 per tooth every 5 years. • **0%** of the cost for bridges, complete dentures, partial dentures up to 1 every 5 years. • **0%** of the cost for other restorative services - core buildup and prefabricated post and core up to 1 per tooth per lifetime. • **0%** of the cost for scaling and root planing (deep cleaning) up to 1 per quadrant per year. • **0%** of the cost for periodontal debridement up to 1 per year. • **0%** of the cost for periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **0%** of the cost for intraoral x-rays up to 6 per year. • **0%** of the cost for adjustments to dentures, extractions, root canal up to unlimited per year. • **0%** of the cost for implant services up to 1 per tooth per lifetime. • **0%** of the cost for implant supported prosthetics up to 1 per tooth every 5 years. • **$2500** maximum benefit coverage amount per year for adjustments to dentures, complete dentures, crown, partial dentures, other restorative services - core buildup and prefabricated post and core, bridges, implant services, and implant supported prosthetics. This plan covers additional Platino benefits
VISION SERVICES	
Medicare-covered vision services	**$0** copay
Medicare-covered diabetic eye exam	**$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.

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Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
Medicare-covered glaucoma screening	**$0** copay
Medicare-covered eyewear (post-cataract)	**$0** copay
Routine vision	**VIS316** • **$0** copay for routine exam up to 1 per year. • **$500** maximum benefit coverage amount per year for contact lenses and/or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglasses include ultraviolet protection and scratch resistant coating.
MENTAL HEALTH SERVICES	
Inpatient	**$0** copay per admit
Outpatient group and individual therapy visits	**$0** copay
SKILLED NURSING FACILITY (SNF)	
Your plan covers up to 100 days in a SNF	**$0** copayment per admit
PHYSICAL THERAPY	
	$0 copay
AMBULANCE	
Ambulance	**$0** copay per date of service
TRANSPORTATION	
	$0 copay for plan approved location up to 24 one-way trip(s) per year. The member *must* contact transportation vendor to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider.
MEDICARE PART B DRUGS	
Chemotherapy drugs	**$0** copay
Other Part B drugs	**$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.

Prescription Drug Benefits

PRESCRIPTION DRUGS	
Medicare Part D Drugs	See chart below for plan coverage information for prescription drugs

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 **$4,660**. 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.

Mail Order Cost-Sharing		
Pharmacy options	**Mail Order** CenterWell Pharmacy™, Walmart Mail Other pharmacies are available in our network. To find pharmacy mail order options go to **Humana.com/pharmacyfinder**	
	30-day supply	**90-day supply***
Tier 1: Preferred Generic	$0	$0
Tier 2: Generic	$0	$0
Tier 3: Preferred Brand	$0	$0
Tier 4: Non-Preferred Drug	$0	$0
Tier 5: Specialty Tier	$0	N/A
Tier 6: Select Care Drugs	$0	$0

Retail Cost-Sharing		
Pharmacy options	**Retail** All network retail pharmacies. To find the retail pharmacies near you, go to **Humana.com/pharmacyfinder**	
	30-day supply	**90-day supply***
Tier 1: Preferred Generic	$0	$0
Tier 2: Generic	$0	$0
Tier 3: Preferred Brand	$0	$0
Tier 4: Non-Preferred Drug	$0	$0
Tier 5: Specialty Tier	$0	N/A
Tier 6: Select Care Drugs	$0	$0

Other pharmacies are available in our network.
*Some drugs are limited to a 30-day supply

For more information on pharmacy-specific cost-sharing, please call us or refer to Chapter 6 of the Evidence of Coverage for more details.

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

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

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
Tier 6 (Select Care Drugs) - All Drugs

For more information on cost sharing in the coverage gap, please call us or access your 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 **$7,400**, 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
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
Medical Supplies	**$0** copay
Prosthetics (artificial limbs or braces)	**$0** copay
Diabetic monitoring supplies	**$0** copay
REHABILITATION SERVICES	
Occupational and speech therapy	**$0** copay
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
Substance abuse or behavioral health services	**$0** copay

Medicaid Benefit Comparison

The benefits described in the Covered Medical and Hospital Benefits sections above are covered by Humana Gold Plus SNP-DE H4007-019 (HMO D-SNP). Below is a comparison of benefits that some Medicaid eligible individuals could receive directly from the Administración de Seguros de Salud (ASES) (Medicaid). For each benefit listed below, you can see what the Administración de Seguros de Salud (ASES) (Medicaid) covers and what our plan covers. All Medicaid benefits are subject to Medicaid eligibility guidelines and requirements, and are available only to full dual eligible individuals. If you have questions about your Medicaid eligibility and what benefits you are entitled to, review your member handbook or contact the Administración de Seguros de Salud (ASES) (Medicaid) at 1-787-641-4224.

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Acute inpatient hospital care	Covered	Covered
Ambulance	Covered	Covered
Ambulatory surgical center	Covered	Covered
Dental services preventive & restorative (Medicaid Covered)	**Co-Payment Code** **Preventive (Child) 100-$0.00 / 110-$0.00 / 120-$0.00 / 130-$0.00** **Preventive (Adult) 100-$0.00 / 110-$1.00 / 120-$1.50 / 130-$2.00** **Restorative 100-$0.00 / 110-$1.00 / 120-$1.50 / 130-$2.00** Dental services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. The following are the benefits included in the GHP; • All preventative and corrective services for children under age twenty-one (21) mandated by the EPSDT requirement • Pediatric Pulp Therapy (Pulpotomy) for children under age twenty-one (21); • Stainless steel crowns for use in primary teeth following a Pediatric Pulpotomy; • Preventive dental services for Adults;	Covered

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
	• Restorative dental services for Adults; • One (1) comprehensive oral exam per year; • One (1) periodical exam every six months; • One (1) defined problem-limited oral exam; • One (1) full series of intra oral radiographies, including bite, every three (3) years. • One (1) initial periapical intra-oral radiography; • Up to five (5) additional periapical/intra-oral radiographies per year; • One (1) single film-bite radiography per year; • One (1) two-film bite radiography per year; • One (1) panoramic radiography every three (3) years; • One (1) adult cleanse every six (6) months; • One (1) child cleanse every six (6) months; • One (1) topical fluoride application every six (6) months for Enrollees under nineteen (19) years old; • Fissure sealants for life for Enrollees up to fourteen (14) years old, including decidual molars up to eight (8) years old when Medically Necessary because of cavity tendencies; • Amalgam restoration; • Resin restorations; • Root Canal; • Palliative treatment; and • Oral Surgery	
Dentures	Not Covered	Covered
Diagnostic services/labs/imaging	Covered	Covered

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Doctor office visits (Primary care provider (PCP)/specialists	Covered	Covered
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) under 21 years (Medicaid Covered)	**Co-Payment code 100-$0.00 / 110-$0.00 / 120-$0.00 / 130-$0.00** EPSDT requirements non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. EPSDT Checkups must include all of the following: 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. (Reference must be made to the corresponding CMS EPSDT guidelines and ASES policy.)	Covered
Emergency care	Covered	Covered
Eyeglasses	Not Covered	Covered
Family planning (Medicaid Covered)	**Co-Payment code 100-$0.00 / 110-$0.00 / 120-$0.00 / 130-$0.00** Family Planning services non-covered by Medicare and/or	Covered

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
	the MAO supplementary benefits but included in the State Plan. Puerto Rico Medicaid benefits provide reproductive health and family planning counseling. Such services shall be provided voluntarily and confidentially, including circumstances where 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: • Contra-indication with drugs that the Enrollee is already taking, and no other methods covered/available that can be used by the Enrollee. • History of adverse reaction by the Enrollee to the contraceptive methods covered.	

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
	• History of adverse reaction by the Enrollee to the contraceptive medications that are covered.	
Hearing aids	Not Covered	Covered
Hearing exams (Medicaid Covered)	**Co-Payment Code 100-$0.00 / 110-$1.00 / 120-$1.50 / 130-$2.00** Hearing related services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Hearing aids for beneficiaries over 20 years old are excluded from coverage. Refer to ESPDT for hearing cover services.	Covered
Inpatient hospital, nursing facility and intermediate care facility services in institutions for mental diseases (MD), age 65 and older	Not Covered	Covered with limitations
Inpatient hospital for mental health diseases (Medicaid Covered)	**Co-Payment Code 100-$0.00 / 110-$4.00 / 120-$5.00 / 130-$8.00** Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage and 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).	Covered
Inpatient hospital services (Medicaid Covered)	**Co-Payment Code 100-$0.00 / 110-$4.00 / 120-$5.00 / 130-$8.00** Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage and included as covered services on Medicaid state	Covered

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
	plan. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year). Coverage includes: • Isolation room for medical reasons • Specialized diagnostic/treatment such as electrocardiograms, electroencephalograms, arterial gases, and other specialized diagnostic and/or treatment testing that are available in the hospital facilities and which are required to be performed while the patient is hospitalized. • Short Term Rehabilitation Services: To hospitalize patients, including physical, occupational, and speech therapy. Blood: Blood, plasma and their derivatives without limitations, to include irradiated and autologous blood; Monoclonal Factor IX per authorization of a certified hematologist; Antihemophilic Factor with intermediate purity concentration (Factor VIII) A; Antihemophilic Monoclonal Type Factor per authorization of a certified hematologist and Prothrombin Activated complex (Auto flex and Feiba) per authorization of a certified hematologist.	
Inpatient psychiatric services, under age 21	Not Covered	Covered with limitations

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Inpatient substance use disorder (Medicaid Covered)	**Co-Payment Code 100-$0.00 / 110-$4.00 / 120-$5.00 / 130-$8.00** Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage and 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).	Covered
Intermediate care facility services for individuals with intellectual disabilities	Not Covered	Covered with limitations
Laboratory and high-tech laboratories (Medicaid Covered)	**Co-Payment Code 100-$0.00 / 110-50¢ / 120-$1.00 / 130-$1.50** Laboratory testing and necessary procedures related to generating a Health Certificate non-covered by Medicare or the MAO supplementary benefits but included in the State Plan.	Covered
Maternity services (Medicaid covered)	**Co-Payment code 100-$0.00 / 110-$0.00 / 120-$0.00 / 130-$0.00** Maternity services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Abortions when the pregnancy is a result of rape or incest as certified by a physician. Severe and long-lasting damage would be caused to the mother if the pregnancy is carried to term as certified by a physician.	Covered

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Medical and surgical (Medicaid covered)	**Co-Payment Code 100-$0.00 / 110-$1.00 / 120-$1.50 / 130-$2.00** Medical and Surgical services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. 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 included as Appendix (O) 23 of the Contract.	Covered
Mental health services (outpatient group therapy and individual therapy visit)	Covered	Covered
Nursing facility services, other than in an institution for mental diseases	Not Covered	Covered with limitations
Outpatient hospital coverage	Covered	Covered
Outpatient mental healthcare & professional services (Medicaid Covered)	**Co-Payment Code 100-$0.00 / 110-$1.00 / 120-$1.50 / 130-$2.00** 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.	Covered

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Outpatient substance use disorder (Medicaid Covered)	**Co-Payment Code 100-$0.00 / 110-$1.00 / 120-$1.50 / 130-$2.00** Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage and 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.	Covered
Physical, occupational, speech therapy (Medicaid Covered)	**Co-Payment Code 100-$0.00 / 110-$1.00 / 120-$1.50 / 130-$2.00** Covered without limits under Medicare Part B (Medical Insurance). Do not apply within Wrap-Around.	Covered
Physical therapy	Covered	Covered
Prescription drugs (Medicaid Covered)	**Co-Payment code 100-$0.00 / 110-$0.00 / 120-$0.00 / 130-$0.00 Preferred (Children 0-21)** **Co-Payment code 100-$0.00 / 110-$1.00 / 120-$2.00 / 130-$3.00 Preferred (Adult)****** **Co-Payment code 100-$0.00 / 110-$0.00 / 120-$0.00 / 130-$0.00 Non-Preferred (Children 0-21)** **Co-Payment code 100-$0.00 / 110-$3.00 / 120-$4.00 / 130-$6.00 Non-Preferred (Adult)****** **Co-Payment code 100-$0.00 / 110-$0.00 / 120-$0.00 / 130-$0.00 Outpatient Substance Abuse** Prescription drugs non-covered by Medicare and/or the MAO	Covered

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
	supplementary benefits but included in the State Plan. Any cost sharing not included on the MAO benefit design as approved by CMS, including deductible, co insurances or coverage gaps exceeding the State plan 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 followings: • 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, the drug will be covered under Wrap-Around. The prescriber physician needs to exhaust available MAO Formulary on the needed drug category. • Wrap around drugs to be considered need to be part of the GHP Formulary. All MAO's Part D Drugs Formularies should have the same therapeutic classes as GHP Formulary.	

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Prescription drugs – Medicare Part B drugs	Not Covered	Covered
Prescription drugs – outpatient prescription drugs; Medicare covered & non-Medicare covered	Not Covered	Covered
Preventive care (e.g., flu vaccine, diabetic screenings)	Covered	Covered
Preventative services (Medicaid Covered)	**Co-Payment code 100-$0.00 / 110-$0.00 / 120-$0.00 / 130-$0.00** Immunization services non-covered by; 1-Medicare Part B. 2-MAO Part D drug formulary. 3-MAO supplementary plan benefits. 4-Not covered by the Puerto Rico Department of Health Immunization Program but included in the Puerto Rico Medicaid State Plan.	Covered
Routine non-emergency medical transportation	Not Covered	Covered
Skilled nursing facility	Not Covered	Covered
Tobacco cessation (Medicaid Covered)	**Co-Payment code 100-$0.00 / 110-$0.00 / 120-$0.00 / 130-$0.00** Tobacco cessation services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Smoking cessation drugs are covered for individuals under age 21 and for pregnant women when medically necessary and prescribed by a physician. In these cases, the plan covers prescription and non-prescription aids as indicated by a physician.	Covered
Urgently needed services	Covered	Covered

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Vision services (Medicaid Covered)	**Co-Payment Code 100-$0.00 / 110-$1.00 / 120-$1.50 / 130-$2.00** Vision services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Eyeglasses or lenses for beneficiaries between the ages of 0-20 years when **medically necessary** will be cover, the benefit of eyeglasses and lens consist of a single or multifocal lens and a standard frame eyeglass every 24 months. All types of lens have to be preauthorized 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.	Covered

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.
This is a summary of what we cover. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of coverage and services. Visit **Humana.com/medicare** to view a copy of the EOC or call **1-800-681-3625**.

Humana Flex Allowance

$500 annual allowance on a prepaid card to use toward out of pocket costs for the plan's preventive and comprehensive dental, vision, or hearing services including copays.
Members can use this benefit at participating providers where the primary business is Dental Care, Vision Services, or Hearing Services and Visa® is accepted.
Cannot be used for procedures such as cosmetic dentistry and teeth whitening.
Unused amount expires at the end of the plan year.

Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

Humana Spending Account Card

The allowance listed below will be loaded onto this prepaid card. Each allowance is separate from any other allowance listed. Allowances shown are accessed by using this card. Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

*Humana Flex Allowance

Humana Extra Debit Card

$75 automatically loaded on a debit card every month to use toward the purchase of needed goods and services and pay monthly expenses. Unused funds will roll over to the next month and expire at the end of the plan year. Limitations and restrictions may apply.

Smoking cessation program

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

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

You may receive one blood pressure monitor every five (5) years.

Humana Well Dine® Meal Program

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

Rewards and Incentives
Go365 by Humana® a Rewards and Incentive program 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 **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 12/31/2025 based on a review of Humana's Model of Care.

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.

**Humana encourages use of the Humana Extra Debit Card towards items and services that promote improved health, and prevention of injury and illness. Humana and its subsidiaries are not liable for member purchase decisions using the Humana Extra Debit Card. For questions regarding your plan benefits, please call Customer Care at 1-866-773-5959 (TTY: 711).

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

Important

At Humana, it is important you are treated fairly.

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

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-866-773-5959** 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. 1-866-773-5959 (TTY: 711)

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

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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-773-5959 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-773-5959 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-866-773-5959 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-866-773-5959 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-773-5959 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-773-5959 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-866-773-5959 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-773-5959 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다 . 통역 서비스를 이용하려면 전화 1-866-773-5959 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-773-5959 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-773-5959 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-773-5959 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-773-5959 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-773-5959 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-773-5959 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-773-5959 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康健康保険と薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-866-773-5959 (TTY: 711) にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

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