2016

Summary of Benefits

Humana Gold Plus®
SNP-DE H3533-022 (HMO SNP)

Long Island
Nassau and Suffolk*(partial) counties

Humana®

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Humana®

SECTION 1

Summary of Benefits
January 1, 2016 - December 31, 2016

This booklet gives you 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. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Humana Gold Plus SNP-DE H3533-022 (HMO SNP)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Humana Gold Plus SNP-DE H3533-022 (HMO SNP)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your 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, 7 days a week. TTY users should call **1-877-486-2048**.

Sections in this booklet

- Things to Know About **Humana Gold Plus SNP-DE H3533-022 (HMO SNP)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.
This document may be available in a non-English language. For additional information, call us at 1-800-457-4708.
Es posible que este documento esté disponible en otros idiomas aparte de inglés. Para obtener información adicional, llame al Servicio al Cliente al número de teléfono que se indica a continuación.

Things to Know About Humana Gold Plus SNP-DE H3533-022 (HMO SNP)

Hours of Operation

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Local time.
- From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Local time.

Humana Gold Plus SNP-DE H3533-022 (HMO SNP) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-800-457-4708 .
- If you are not a member of this plan, call toll-free 1-800-833-2364 .
- Our website: **http://www.humana-medicare.com**

Who can join?

To join **Humana Gold Plus SNP-DE H3533-022 (HMO SNP)** , you must be entitled to Medicare Part A, be enrolled in Medicare Part B and the New York State Department of Health (SDOH) Medicaid Program, and live in our service area.
Our service area includes the following counties in New York: Nassau and Suffolk*.
* denotes partial county

Which doctors, hospitals, and pharmacies can I use?

Humana Gold Plus SNP-DE H3533-022 (HMO SNP) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services .
You must generally use network pharmacies to fill your prescriptions for covered Part D drugs .
Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies .
You can see our plan's provider directory at our website (www.humana.com/members/tools) .
You can see our plan's pharmacy directory at our website (https://www.humana.com/pharmacy/medicare/) .
Or, call us and we will send you a copy of the provider and pharmacy directories .

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and more.

- **Our plan members get all of the benefits covered by Original Medicare.**
- **Our plan members also get more than what is covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider .

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, https://www.humana.com/pharmacy/medicare/tools/druglist/ .
- Or, call us and we will send you a copy of the formulary .

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Summary of Benefits
January 1, 2016 - December 31, 2016

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services	
How much is the monthly premium?	**$0** per month.
How much is the deductible?	This plan does not have a deductible. This plan does not have a deductible for chemotherapy and other drugs administered in your doctor's office (Part B drugs). This plan does not have a deductible for Part D prescription drugs.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. In this plan, you may pay nothing for Medicare-covered services, depending on your level of New York State Department of Health (SDOH) eligibility. Your yearly limit(s) in this plan: • **$6,700** for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Refer to the **"Medicare & You"** handbook for Medicare-covered services. For New York State Department of Health (SDOH)-covered services, refer to the Medicaid Coverage section in this document. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

Covered Medical and Hospital Benefits	
Note: • Services with a [1] may require prior authorization. • Services with a [2] may require a referral from your doctor.	
OUTPATIENT CARE AND SERVICES	
Acupuncture	Not covered
Ambulance[1]	**You pay nothing**
Chiropractic Care[1]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): **You pay nothing**

SECTION 2 (continued)

Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): **You pay nothing** Preventive dental services: Cleaning (for up to 2 every year): **$0** copay after you pay your deductible Dental x-ray(s) (for up to 2 every year): **$0** copay after you pay your deductible Oral exam (for up to 2 every year): **$0** copay after you pay your deductible Our plan pays up to **$2,000** every year for most dental services. Additional benefits are covered by your plan. For detailed benefit information please call the Customer Care number listed in the "Things To Know About Your Plan" section above.
Diabetes Supplies and Services[1]	Diabetes monitoring supplies: **You pay nothing** Diabetes self-management training: **You pay nothing** Therapeutic shoes or inserts: **You pay nothing**
Diagnostic Tests, Lab and Radiology Services, and X-Rays *(Costs for these services may be different if received in an outpatient surgery setting)*[1]	Diagnostic radiology services (such as MRIs, CT scans): **You pay nothing** Diagnostic tests and procedures: **You pay nothing** Lab services: **You pay nothing** Outpatient x-rays: **You pay nothing** Therapeutic radiology services (such as radiation treatment for cancer): **You pay nothing**
Doctor's Office Visits[1]	Primary care physician visit: **You pay nothing** Specialist visit: **You pay nothing**
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	**You pay nothing**
Emergency Care	**You pay nothing**
Foot Care *(podiatry services)*[1]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: **You pay nothing**

Hearing Services	Exam to diagnose and treat hearing and balance issues: **You pay nothing** Routine hearing exam (for up to 1 every year): **You pay nothing** Hearing aid fitting/evaluation (for up to 1 every year): **You pay nothing** Hearing aid: **$0** copay Our plan pays up to **$1,000** every three years for hearing aids. **You pay nothing** up to the **$1000** allowance every three years.
Home Health Care[1]	**You pay nothing**
Mental Health Care[1]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. **You pay nothing** Outpatient group therapy visit: **You pay nothing** Outpatient individual therapy visit: **You pay nothing**
Outpatient Rehabilitation[1]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): **You pay nothing** Occupational therapy visit: **You pay nothing** Physical therapy and speech and language therapy visit: **You pay nothing**
Outpatient Substance Abuse[1]	Group therapy visit: **You pay nothing** Individual therapy visit: **You pay nothing**
Outpatient Surgery[1]	Ambulatory surgical center: **You pay nothing** Outpatient hospital: **You pay nothing**

Over-the-Counter Items	Please visit our website to see our list of covered over-the-counter items. – You are eligible to receive a **$100** monthly benefit toward the purchase of selected over-the-counter items when you use Humana's mail order service. – For more information or to request an order form, please call Customer Care.
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: **You pay nothing** Related medical supplies: **You pay nothing**
Renal Dialysis[1]	**You pay nothing**
Transportation[1]	**You pay nothing** – 24 one-way non-emergency trips per year for plan approved locations. – This benefit is not to exceed 25 miles per trip.
Urgently Needed Services	**You pay nothing**
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): **You pay nothing** Routine eye exam (for up to 1 every year): **You pay nothing** Contact lenses (for up to 1 every year): **$0** copay Eyeglasses (frames and lenses) (for up to 1 every year): **$0** copay Eyeglasses or contact lenses after cataract surgery: **You pay nothing** Our plan pays up to **$300** every year for contact lenses and eyeglasses (frames and lenses). **You pay nothing** up to the **$300** allowance every year.

Preventive Care	**You pay nothing** Our plan covers many preventive services, 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 • 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) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered. Annual physical exam: **You pay nothing**
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.
INPATIENT CARE	
Inpatient Hospital Care[1]	Our plan covers an unlimited number of days for an inpatient hospital stay. **You pay nothing** • **$630** copay per day for days 91 through 150 • **You pay nothing** per day for days 151 and beyond
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet
Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF. **You pay nothing**

Prescription Drug Benefits

How much do I pay?

For Part B drugs such as chemotherapy drugs[1]: **You pay nothing**

Other Part B drugs[1]: **You pay nothing**.

Initial Coverage

You pay the following:
You may get your drugs at network retail pharmacies and mail order pharmacies.

Standard Retail Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	**$0**	**$0**
Tier 2 (Generic)	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.
Tier 3 (Preferred Brand)	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.

Tier 4 (Non-Preferred Brand)	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.
Tier 5 (Specialty Tier)	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.	Not Offered

Standard Mail Order Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	**$0**	**$0**
Tier 2 (Generic)	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.

	Tier 3 (Preferred Brand)	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.
	Tier 4 (Non-Preferred Brand)	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.
	Tier 5 (Specialty Tier)	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.	Not Offered

Preferred Mail Order Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	**$0**	**$0**
Tier 2 (Generic)	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.	**$0**
Tier 3 (Preferred Brand)	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.

	Tier 4 (Non-Preferred Brand)	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.
	Tier 5 (Specialty Tier)	• For generic drugs (including brand drugs treated as generic), either: **$0** copay; or **$1.20** copay; or **$2.95** copay • For all other drugs, either: **$0** copay; or **$3.60** copay; or **$7.40** copay.	Not Offered
	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 Days' Supply Available Unless otherwise specified, you can get your Part D medicine in the following days' supply: – 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	**You pay nothing**.		

Additional Information About Humana Gold Plus SNP-DE H3533-022 (HMO SNP)

As a member you must select an in-network doctor to act as your Primary Care Physician (PCP). Your selected in-network PCP can focus on your needs and coordinate your care with other in-network physicians. This helps keep your out-of-pocket costs low and medical expenses predictable.

Additional Supplemental Benefits covered by the plan:
Incentive Programs - Rewards members for completing preventive screenings and activities
SilverSneakers® Fitness Program - Basic fitness center membership including fitness classes
Well Dine Meal Program - Humana's meal program for members following an inpatient stay in the hospital or nursing facility
Member Assistance Program - A program that includes telephonic counseling sessions and online resources to help cope with life changes and consultations for adult care and child care issues
Humana Health Coaching - A one-on-one wellness coaching program with email, phone, and online chat options
HumanaFirst® - A 24 Hour Nurse Advice Hotline

Section 4 – Medicare and Medicaid Comparison

Dual Eligible Special Needs Plans Overview

- Humana Gold Plus SNP-DE H3533-022 (HMO SNP) is a Coordinated Care plan with a Medicare contract and a contract with the New York Medicaid program. Enrollment in this Humana plan depends on contract renewal.
- To enroll in a Dual Eligible Special Needs Plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B and also receive certain levels of assistance from your state Medical Assistance Program (Medicaid). If you receive both Medicare and Medicaid benefits, this means you are a dual eligible.
- Humana Gold Plus SNP-DE H3533-022 (HMO SNP) may enroll dual eligibles who are QMB Plus, QMB, and FBDE.
- As a member of this plan, you will not be responsible for cost sharing for plan benefits.
- The Comprehensive Benefit Chart below 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.
- If you have any questions about your benefits or your level of eligibility for assistance from Medicaid, you should contact Humana's customer service department or your state Medicaid office for further details. You will find Humana's toll-free phone numbers at the end of Section I of this booklet and the phone number for your state's Medicaid office is at the end of this section.

Comprehensive Benefit Chart

Humana Gold Plus SNP-DE H3533-022 (HMO SNP)

Covered Medical and Hospital Benefits

Note:

- Humana Gold Plus SNP-DE H3533-022 (HMO SNP) services with a [1] may require prior authorization.
- Humana Gold Plus SNP-DE H3533-022 (HMO SNP) services with a [2] may require a referral from your doctor.

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H3533-022 (HMO SNP)
OUTPATIENT CARE AND SERVICES		
Acupuncture	For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copayments, and deductibles for Original Medicare covered services. Medicaid usual limits and copayments for this service: • Not covered.	Not covered
Ambulance[1]	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	**You pay nothing**
Chiropractic Care[1]	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): **You pay nothing**

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H3533-022 (HMO SNP)
Dental Services	For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copayments, and deductibles for Original Medicare covered services. Medicaid usual limits and copayments for this service: • Dental services include, but shall not be limited to necessary preventive, prophylactic and other routine dental care, services and supplies and dental prosthetics to alleviate a serious health condition. • Ambulatory or inpatient surgical dental services subject to prior authorization.	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): **You pay nothing** Preventive dental services: Cleaning (for up to 2 every year): **$0** copay after you pay your deductible Dental x-ray(s) (for up to 2 every year): **$0** copay after you pay your deductible Oral exam (for up to 2 every year): **$0** copay after you pay your deductible Our plan pays up to **$2,000** every year for most dental services. Additional benefits are covered by your plan. For detailed benefit information please call the Customer Care number listed in the "Things To Know About Your Plan" section above.
Diabetes Supplies and Services[1]	For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copayments, and deductibles for Original Medicare covered services.	Diabetes monitoring supplies: **You pay nothing** Diabetes self-management training: **You pay nothing** Therapeutic shoes or inserts: **You pay nothing**

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H3533-022 (HMO SNP)
Diagnostic Tests, Lab and Radiology Services, and X-Rays *(Costs for these services may be different if received in an outpatient surgery setting)*[1]	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	Diagnostic radiology services (such as MRIs, CT scans): **You pay nothing** Diagnostic tests and procedures: **You pay nothing** Lab services: **You pay nothing** Outpatient x-rays: **You pay nothing** Therapeutic radiology services (such as radiation treatment for cancer): **You pay nothing**
Doctor's Office Visits[1]	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	Primary care physician visit: **You pay nothing** Specialist visit: **You pay nothing**
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copayments, and deductibles for Original Medicare covered services. Medicaid usual limits and copayments for this service: • Non-Medicare covered DME	**You pay nothing**
Emergency Care	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	**You pay nothing**
Foot Care *(podiatry services)*[1]	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: **You pay nothing**

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H3533-022 (HMO SNP)
Hearing Services	For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copayments, and deductibles for Original Medicare covered services. Medicaid usual limits and copayments for this service: • Medicaid hearing services and products when medically necessary to alleviate disability caused by the loss or impairment of hearing. • Services include hearing aid selecting, fitting, and dispensing; hearing aid checks following dispensing, conformity evaluations and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aid prescriptions.	Exam to diagnose and treat hearing and balance issues: **You pay nothing** Routine hearing exam (for up to 1 every year): **You pay nothing** Hearing aid fitting/evaluation (for up to 1 every year): **You pay nothing** Hearing aid: **$0** copay Our plan pays up to **$1,000** every three years for hearing aids. **You pay nothing** up to the **$1000** allowance every three years.
Home Health Care[1]	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	**You pay nothing**
Mental Health Care[1]	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H3533-022 (HMO SNP)
		inpatient hospital coverage will be limited to 90 days. **You pay nothing** Outpatient group therapy visit: **You pay nothing** Outpatient individual therapy visit: **You pay nothing**
Outpatient Rehabilitation[1]	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): **You pay nothing** Occupational therapy visit: **You pay nothing** Physical therapy and speech and language therapy visit: **You pay nothing**
Outpatient Substance Abuse[1]	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	Group therapy visit: **You pay nothing** Individual therapy visit: **You pay nothing**
Outpatient Surgery[1]	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	Ambulatory surgical center: **You pay nothing** Outpatient hospital: **You pay nothing**
Over-the-Counter Items	For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copayments, and deductibles for Original Medicare covered services. Medicaid usual limits and copayments for this service: • Certain OTC drugs are covered.	Please visit our website to see our list of covered over-the-counter items. – You are eligible to receive a **$100** monthly benefit toward the purchase of selected over-the-counter items when you use Humana's mail order service. – For more information or to request an order form, please call Customer Care.

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H3533-022 (HMO SNP)
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	Prosthetic devices: **You pay nothing** Related medical supplies: **You pay nothing**
Renal Dialysis[1]	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	**You pay nothing**
Transportation[1]	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	**You pay nothing** – 24 one-way non-emergency trips per year for plan approved locations. – This benefit is not to exceed 25 miles per trip.
Urgently Needed Services	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	**You pay nothing**

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H3533-022 (HMO SNP)
Vision Services	For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copayments, and deductibles for Original Medicare covered services. Medicaid usual limits and copayments for this service: • Services of optometrists, ophthalmologists and ophthalmic dispensers. • Coverage also includes examinations for diagnosis and treatment for visual defects and/or eye disease. • Examinations for refraction are limited to every two (2) years unless otherwise justified as medically necessary.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): **You pay nothing** Routine eye exam (for up to 1 every year): **You pay nothing** Contact lenses (for up to 1 every year): **$0** copay Eyeglasses (frames and lenses) (for up to 1 every year): **$0** copay Eyeglasses or contact lenses after cataract surgery: **You pay nothing** Our plan pays up to **$300** every year for contact lenses and eyeglasses (frames and lenses). **You pay nothing** up to the **$300** allowance every year.
Preventive Care	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	**You pay nothing** Our plan covers many preventive services, 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

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H3533-022 (HMO SNP)
		• 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) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered. Annual physical exam: **You pay nothing**
Hospice	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	**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.
INPATIENT CARE Inpatient Hospital Care[1]	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	Our plan covers an unlimited number of days for an inpatient hospital stay. **You pay nothing** • **$630** copay per day for days 91 through 150 • **You pay nothing** per day for days 151 and beyond

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H3533-022 (HMO SNP)
Inpatient Mental Health Care	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	For inpatient mental health care, see the "Mental Health Care" section of this booklet
Skilled Nursing Facility (SNF)[1]	For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	Our plan covers up to 100 days in a SNF. **You pay nothing**
Prescription Drug Benefits		
Outpatient Prescription Drugs	Medicaid usual limits and copayments for this service: • Medicaid covers Medicaid prescription drugs not covered by a Medicare Prescription Drug Plan. • Copayments: – **$3** Brand – **$1** Generic – **$0.50** OTC	For Part B drugs such as chemotherapy drugs[1]: **You pay nothing** Other Part B drugs[1]: **You pay nothing**. You pay the following: You may get your drugs at network retail pharmacies and mail order pharmacies. For more detailed information on Prescription Drug Benefits for this plan see Section 2.

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 New York State Department of Health (SDOH) Medicaid Program covers and what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility. If you have questions about your Medicaid eligibility and what benefits you are entitled to call: 1-800-541-2831.

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H3533-022 (HMO SNP)
PRODUCTS AND DEVICES		
Dentures	• Not covered.	See Section 2 for more information regarding Humana Gold Plus Dental Services benefit.

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H3533-022 (HMO SNP)
Eyeglasses	• Services of optometrists, ophthalmologists and ophthalmic dispensers including eyeglasses, medically necessary contact lenses and poly-carbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Coverage also includes the repair or replacement of parts. • Eyeglasses do not require changing more frequently than every two (2) years unless medically necessary or unless the glasses are lost, damaged or destroyed.	See Section 2 for more information regarding Humana Gold Plus Vision Services benefit.
Hearing Aids	• Covers hearing aid products including hearing aids, ear molds, special fittings and replacement parts.	See Section 2 for more information regarding Humana Gold Plus Hearing Services benefit.
TRANSPORTATION		
Non-Emergency Medical Transportation Services	• Transportation expenses are covered when transportation is essential in order for a Member to obtain necessary medical care and services under the Medicaid program. Transportation services means transportation by ambulance, ambulette, fixed wing or airplane transport, invalid coach, taxicab, livery, public transportation, or other means appropriate to the enrollee's medical condition and a transportation attendant to accompany the enrollee, if necessary.	See Section 2 for more information regarding Humana Gold Plus Transportation benefit.
INPATIENT LONG TERM CARE SERVICES		
Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services in Institutions for Mental Diseases (IMD), age 65 and older	• Covered. • Inpatient mental health over 190-Day Lifetime limit.	Not covered.

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H3533-022 (HMO SNP)
Inpatient Psychiatric Services, under age 21	• Covered	See Section 2 for more information regarding Humana Gold Plus Inpatient Mental Health benefit.
Intermediate Care Facility Services for the Mentally Retarded	• Covered	Not covered.
Nursing Facility Services, other than in an Institution for Mental Diseases	• Covered. • Skilled nursing facility days provided by a licensed facility in excess of the first 100 days in the Medicare Advantage benefit period. • Institutional Medicaid coverage for permanent placement is required.	See Section 2 for more information regarding Humana Gold Plus Skilled Nursing Facility benefit.
COMMUNITY BASED LONG TERM CARE AND MENTAL HEALTH SERVICES		
Personal Care Services	• Services such as housekeeping, meal preparation, bathing, toileting, and grooming.	Not Covered.
Certain Mental Health Services including:	• Intensive Psychiatric Rehabilitation Treatment Programs. • Day Treatment. • Continuing Day Treatment. • Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units). • Partial Hospitalizations Assertive Community -Treatment (ACT). • Personalized Recovery Oriented Services (PROS).	Not Covered.
Medical Social Services	• Service to assess the need for, arranging for and providing aid for social problems related to the maintenance of a patient in the home. • Services must be provided by a qualified social worker and provided within a plan of care.	Not Covered.
Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs	• Covered	Not Covered.

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H3533-022 (HMO SNP)
Comprehensive Medicaid Case Management	• Covered	Not Covered.
Adult Day Health Care	• ADHC's provide a comprehensive range of services in a community-based, non-institutional setting. General medical care, including treatment adherence support, nursing care, nutritional services, case management, HIV risk reduction, substance abuse, mental health and rehabilitative services are among those provided.	Not Covered.
Personal Emergency Response System	• An electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency.	Not Covered.

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 1-800-541-2831.

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 7/1/2015. All Medicaid covered services are subject to change at any time. For the most current New York Medicaid coverage information, please visit the New York Medicaid website at http://www.health.ny.gov/health_care/medicaid/ or call the Medicaid Hotline at 1-800-541-2831.

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Notes

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 1-800-457-4708. Someone who speaks English/Language 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 1-800-457-4708. 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 1-800-457-4708。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 1-800-457-4708。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 1-800-457-4708. 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 1-800-457-4708. 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 1-800-457-4708. 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 1-800-457-4708. 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 1-800-457-4708 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 1-800-457-4708. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات الترجمة الفورية المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الإتصال بنا على.1-800-457-4708. سيقوم شخص ما يتحدث اللغة العربية بمساعدتك. هذه الخدمة 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 1-800-457-4708 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 1-800-457-4708. 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 1-800-457-4708. 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 1-800-457-4708. 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 1-800-457-4708. 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、1-800-457-4708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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