2024

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.

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, 2025.
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ 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.

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, please refer to the plan's Evidence of Coverage on our website, **Humana.com/plandocuments**.

As a member you must select an in-network doctor in your service area listed in this document 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 visit our website: **Humana.com/medicare**.

Medicaid benefits last validated on 07/01/2023 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 (Local and Toll Free) 1-787-625-6955 (TTY).

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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 **$99** but by no more than Original Medicare's Part B Premium for 2024.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	**$0** deductible
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for covered medical services for the year	**$3,400** in-network

Covered Medical and Hospital Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN
INPATIENT HOSPITAL CARE	
	$0 copay per admit
OUTPATIENT HOSPITAL COVERAGE Services listed below may also be covered at other places of treatment. Please refer to specific services listed in this document for additional information.	
Advanced imaging services (MRI, MRA, PET and CT scan)	**$0** copay
Basic radiological services (X-rays)	**$0** copay
Cardiac rehabilitation services	**$0** copay
Chemotherapy drugs	**$0** copay
Diagnostic colonoscopy	**$0** copay
Diagnostic mammography	**$0** copay
Diagnostic procedures and tests - other	**$0** copay
Lab services	**$0** copay
Medicare Part B covered drugs	**$0** copay
Mental health services	**$0** copay
Nuclear medicine services	**$0** copay
Occupational therapy	**$0** copay
Opioid treatment program services	**$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
Physical therapy	**$0** copay
Pulmonary rehabilitation services	**$0** copay
Renal dialysis services	**$0** copay
Sleep study (facility based)	**$0** copay
Speech therapy	**$0** copay
Substance abuse services	**$0** copay
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)	**$0** copay
Surgery services	**$0** copay
Therapeutic radiology (Radiation therapy)	**$0** copay
Wound care	**$0** copay
AMBULATORY SURGERY CENTER	
Diagnostic colonoscopy	**$0** copay
Surgery services	**$0** copay
DOCTOR OFFICE VISITS	
Primary care provider (PCP)	**$0** copay
Specialist	**$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 screening & counseling • Annual Wellness Visit (AWV) • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit • Cardiovascular disease screenings • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training • Glaucoma screening • HIV screening • Immunizations

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Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
	• Lung Cancer Screening • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy • Prostate cancer screening exams • Routine Physical Exam • Sexually transmitted infections (STIs) screening and counseling • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • "Welcome to Medicare" preventive visit 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
Physician and professional services at emergency room	**$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	
Advanced imaging services (MRI, MRA, PET and CT scan)	
• Freestanding radiological facility	**$0** copay
• Primary care physician's office	**$0** copay
• Specialist's office	**$0** copay
Basic radiological services (X-rays)	
• Freestanding radiological facility	**$0** copay
• Primary care physician's office	**$0** copay
• Specialist's office	**$0** copay
• Urgent care center	**$0** copay
Diagnostic colonoscopy at an ambulatory surgery center	**$0** copay

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Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
Diagnostic mammography	
• Freestanding radiological facility	**$0** copay
• Specialist's office	**$0** copay
Diagnostic procedures and tests	
• Primary care physician's office	**$0** copay
• Specialist's office	**$0** copay
• Urgent care center Diagnostic tests and procedures	**$0** copay
Lab services	
• Freestanding laboratory	**$0** copay
• Primary care physician's office	**$0** copay
• Specialist's office	**$0** copay
• Urgent care center	**$0** copay
Nuclear medicine and services at a freestanding radiological facility	**$0** copay
Sleep study	
• Member's home	**$0** copay
• Specialist's office	**$0** copay
Therapeutic radiology (Radiation therapy)	
• Freestanding radiological facility	**$0** copay
• Specialist's office	**$0** copay
HEARING SERVICES	
Medicare-covered hearing	**$0** copay
Mandatory supplemental hearing benefit	**HER905** • **$0** copay for fitting/evaluation, routine hearing exams up to 1 per year. • **$750** maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year.
DENTAL SERVICES	
Medicare-covered dental	**$0** copay
Mandatory supplemental dental benefit Limitations and exclusions may apply. Dental benefits under this plan may not cover all ADA procedure codes. Any services received that are not listed will not be covered by the plan and will be the member's responsibility. The member is responsible for any amount above the dental coverage limit.	**DEN521** • **0%** of the cost for bitewing x-rays up to 1 set(s) every 2 years. • **0%** of the cost for periodontal surgery up to 1 per quadrant every 3 years. • **0%** of the cost for amalgam or composite filling up to 1 per tooth every 3 years.

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Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule	• **0%** of the cost for comprehensive oral exam, cone beam CT imaging, panoramic film up to 1 every 3 years. • **0%** of the cost for crown, implant supported prosthetics up to 1 per tooth every 5 years. • **0%** of the cost for bridges, complete dentures, complete or partial denture reline, partial dentures up to 1 every 5 years. • **0%** of the cost for implant services, 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 pulp vitality test up to 2 per quadrant per year. • **0%** of the cost for periodic oral exam, periodontal maintenance, prophylaxis (cleaning) up to 2 per year. • **0%** of the cost for complete or partial denture repair up to 3 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. • **$2,000** maximum benefit coverage amount per year for adjustments to dentures, bridges, complete dentures, complete or partial denture reline, complete or partial denture repair, crown, implant services, implant supported prosthetics, other restorative services - core buildup and prefabricated post and core, partial dentures comprehensive benefits. This plan covers additional Platino benefits
VISION SERVICES	
Eyewear (post cataract surgery)	**$0** copay
Medicare-covered diabetic eye exam	**$0** copay
Medicare-covered vision services	**$0** copay

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Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
Mandatory supplemental vision benefit	**VIS316** • **$0** copay for routine exam 1 per year. • **$500** maximum benefit coverage amount per year for contact lenses and/or eyeglasses-lenses and frames up to unlimited pair(s) per year, fitting for eyeglasses-lenses and frames up to unlimited per year. • Eyeglasses include ultraviolet protection and scratch resistant coating.
MENTAL HEALTH SERVICES	
Inpatient	**$0** copay per admit
Therapy visits • Partial hospitalization • Specialist's office	 **$0** copay **$0** copay
SKILLED NURSING FACILITY	
Your plan covers up to 100 days in a SNF	**$0** copay per admit
PHYSICAL THERAPY	
Comprehensive outpatient rehab facility	**$0** copay
Specialist's office	**$0** copay
AMBULANCE	
	$0 copay per date of service
TRANSPORTATION	
	$0 copay for plan approved location up to 24 one-way trip(s) per year. This benefit offers unlimited miles per trip. The member *must* contact transportation vendor to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider.

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Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
MEDICARE PART B DRUGS	
Allergy shots and serum	
• Primary care physician's office	**$0** copay
• Specialist's office	**$0** copay
Chemotherapy drugs at a specialist's office	**$0** copay
Other Part B drugs Some rebatable Part B drugs may be subject to a lower coinsurance. You pay no more than $35 for a one-month (up to 30-day) supply for all Part B insulin covered by our plan, and if your plan has a deductible it does not apply to Part B insulin.	
• Pharmacy	**$0** copay
• Primary care physician's office	**$0** copay
• Specialist's office	**$0** copay

Prescription Drug Benefits

PLAN HIGHLIGHTS	
$0 copays	**$0*** for all Medicare Part D covered prescription drugs for the entire calendar year. You will pay **$0** through the Deductible, Initial Coverage, Coverage Gap and Catastrophic Coverage stages.
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

* All Covered drugs have a single-tier benefit structure.

To find which pharmacies are available in your network, go to **Humana.com/pharmacyfinder**.

Some drugs are limited to a 30-day supply

Additional Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN
Chiropractic services (Medicare-covered)	**$0** copay
Podiatry services (Medicare-covered)	**$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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Acupuncture services (Medicare-covered)	**$0** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.
MEDICAL EQUIPMENT/SUPPLIES	
Diabetic monitoring supplies • Diabetic supplier • Network retail pharmacy • Preferred diabetic supplier	 **$0** copay **$0** copay
Durable medical equipment (DME) and related supplies	**$0** copay
Medical Supplies at medical supplier	**$0** copay
Prosthetic devices and related supplies	**$0** copay
REHABILITATION SERVICES	
Cardiac rehabilitation services at a specialist's office	**$0** copay
Occupational therapy • Comprehensive outpatient rehab facility • Specialist's office	 **$0** copay **$0** copay
Physical therapy • Comprehensive outpatient rehab facility • Specialist's office	 **$0** copay **$0** copay
Pulmonary rehabilitation services at a specialist's office	**$0** copay
Speech therapy • Comprehensive outpatient rehab facility • Specialist's office	 **$0** copay **$0** copay
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD) at a specialist's office	**$0** copay
TELEHEALTH SERVICES (in addition to Original Medicare)	
Primary care physician's office	**$0** copay
Specialist's office	**$0** copay
Substance abuse or behavioral health services	**$0** copay
Urgent care 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, what benefits you are entitled to, and any cost-sharing you may be responsible for, review your member handbook or contact the Administración de Seguros de Salud (ASES) (Medicaid) at 1-787-641-4224 (Local and Toll Free) 1-787-625-6955 (TTY).

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Inpatient hospital services (Medicaid Covered)	**Co-Payment Code 100-$0.00 / 110-$0.00 / 120-$0.00 / 130-$0.00** 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). 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.	Covered

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BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
	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.	
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-$0.00 / 120-$0.00 / 130-$0.00** **Restorative 100-$0.00 / 110-$0.00 / 120-$0.00 / 130-$0.00** 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) • Pediatric Pulp Therapy (Pulpotomy) for children under age twenty-one (21); • Stainless steel crowns for use in primary teeth following a Pediatric Pulpotomy;	Covered

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
	• Preventive dental services for Adults; • 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	

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
	• Sedation and anesthesia services for beneficiaries with physical or mental handicaps in compliance with local laws. • Periodontal Scaling and root planning up to 4 cuadrants per beneficiary. • Interim removable partial dentures (upper and lower). • Hospital visits. • All limitations may be exceeded based on medical necessity and approved thorough prior pre authorization or exemption process.	
Dentures	Not Covered	Covered
Diagnostic services, labs, and imaging	Covered	Covered
Doctor office visits	Covered	Covered
Emergency care	Covered	Covered
Eyeglasses	**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 lenses 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

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
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 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

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
	covered/available that can be used by the Enrollee. • History of adverse reaction by the Enrollee to the contraceptive methods covered. • History of adverse reaction by the Enrollee to the contraceptive medications that are covered.	
Hearing aids	Not Covered	Covered
Hearing exams	**Co-Payment code 100-$0.00 / 110-$0.00 /120-$0.00 / 130-$0.00** 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 older are excluded from coverage.	Covered
Home and community based waiver service programs	Covered	Not Covered
Inpatient hospital, nursing facility and intermediate care facility services in institutions for mental diseases (MD), age 65 and older	Covered	Covered with limitations
Inpatient hospital for mental health diseases (Medicaid Covered)	**Co-Payment Code 100-$0.00 / 110-$0.00 / 120-$0.00 / 130-$0.00** 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

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Inpatient psychiatric services, under age 21	Covered	Covered with limitations
Inpatient substance use disorder (Medicaid Covered)	**Co-Payment Code 100-$0.00 / 110-$0.00 / 120-$0.00 / 130-$0.00** 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 facilities for individuals with intellectual disabilities (ICFs-IID)	Covered	Not Covered
Laboratory and high-tech laboratories (Medicaid Covered)	**Co-Payment Code 100-$0.00 / 110-$0.00 / 120-$0.00 / 130-$0.00** 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-$0.00 / 120-$0.00 / 130-$0.00** 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	Covered	Covered
Nursing facility services, other than in an institution for mental diseases	Covered	Covered with limitations
Outpatient hospital coverage	Covered	Covered
Outpatient mental healthcare & professional services (Medicaid Covered)	**Co-Payment Code 100-$0.00 / 110-$0.00 / 120-$0.00 / 130-$0.00** 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-$0.00 / 120-$0.00 / 130-$0.00** 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-$0.00 / 120-$0.00 / 130-$0.00** Covered without limits under Medicare Part B (Medical Insurance). Do not apply within Wrap-Around.	Covered
Physical, occupational, speech therapy	Covered	Covered
Prescription drugs (Medicaid Covered)	**Co-Payment code 100-$0.00 / 110-$1.00 / 120-$2.00 / 130-$3.00 Preferred (Adult)****** **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 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	Covered

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
	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.	
Medicare Part B drugs	Covered	Covered
Preventive care	Covered	Covered

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
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
Transportation	Covered	Covered
Skilled nursing facility	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

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/plandocuments** to view a copy of the EOC or call **1-800-681-3625** .

Humana Extra Debit Card
Members will receive **$60** loaded on a debit card every month to use toward the purchase of OTC products, needed goods and services, and to pay monthly expenses.
Unused funds will roll over to the next month and expire at the end of the plan year.

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
$0 copayment for one (1) contracted standard bath or shower chair with or without wheels, any size every 5 years to members who meet the medical criteria.
Prior authorization requirements may apply.

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 in person and digital fitness classes.

Notes

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Notes

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 (听障专线：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 (聽障專線：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 .

Form CMS-10802 (Expires 12/31/25) Form Approved OMB# 0938-1421

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 بخطتنا الصحية أو خطة الأدوية الموصوفة 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.

Portuguese: 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：当社の健康保険と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をご用意しています。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。日本語を話す者が支援いたします。これは無料のサービスです。

Form CMS-10802 (Expires 12/31/25) Form Approved OMB# 0938-1421

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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.

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

The Part B Premium Reduction benefit pays part or all of your Part B premium and the amount may change based on the amount you pay for Part B.

The information you need is just a click away.

Visit Humana.com/PlanDocuments to check details about your plan, including benefits and costs.

If you'd like a printed Evidence of Coverage, Provider Directory, or Drug List mailed to you, you can request one online at the website above, or call **1-800-457-4708 (TTY: 711)**, 24 hours a day, seven days a week. Please have your Humana member ID card ready when you call. When asked for the reason you've called, say "Evidence of Coverage," "Drug List" or "Provider Directory."

Activate your secure MyHumana account.

Your online MyHumana account is an important part of your Humana membership. Use it to view your plan details anytime and access important plan documents online, all in one place. It's easy to use and tailored to you.

Already have an account?

Go to **Humana.com/MyHumanaPlan** and log in.

Don't have an account yet?

Create one using the same link above in just minutes.

Receiving information about other insurance products

As a Humana member, we may call you to offer other insurance-related products. You can opt out of those future calls by calling the Customer Care number on the back of your ID card.

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Humana Inc.
P.O. Box 14168
Lexington, KY 40512-4168

Important information about your plan

Humana.com

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