

2016 Summary of Benefits

Humana Gold Plus[®]
SNP-DE H1036-239 (HMO SNP)

Raleigh
Raleigh Metro Area



Humana[®]

2016

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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 H1036-239 (HMO SNP)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Humana Gold Plus SNP-DE H1036-239 (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 H1036-239 (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 H1036-239 (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 H1036-239 (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>

SECTION 1 (continued)

Who can join?

To join **Humana Gold Plus SNP-DE H1036-239 (HMO SNP)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and the North Carolina Division of Medical Assistance Medicaid Program, and live in our service area.

Our service area includes the following county in North Carolina: Wake.

Which doctors, hospitals, and pharmacies can I use?

Humana Gold Plus SNP-DE H1036-239 (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.

SECTION 2

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?	<p>This plan does not have a deductible.</p> <p>This plan does not have a deductible for chemotherapy and other drugs administered in your doctor's office (Part B drugs).</p> <p>This plan does not have a deductible for Part D prescription drugs.</p>
Is there any limit on how much I will pay for my covered services?	<p>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.</p> <p>In this plan, you may pay nothing for Medicare-covered services, depending on your level of North Carolina Division of Medical Assistance eligibility.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none">• \$6,700 for services you receive from in-network providers. <p>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.</p> <p>Refer to the "Medicare & You" handbook for Medicare-covered services. For North Carolina Division of Medical Assistance-covered services, refer to the Medicaid Coverage section in this document.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>
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

SECTION 2 (continued)

Chiropractic Care	<p>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</p> <p>Routine chiropractic visit (for up to 12 every year): You pay nothing</p>
Dental Services	<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing</p> <p>Preventive dental services: Cleaning (for up to 1 every year): You pay nothing</p> <p>Dental x-ray(s) (for up to 1 every year): You pay nothing</p> <p>Oral exam (for up to 1 every year): You pay nothing</p> <p>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.</p>
Diabetes Supplies and Services ^{1,2}	<p>Diabetes monitoring supplies: You pay nothing</p> <p>Diabetes self-management training: You pay nothing</p> <p>Therapeutic shoes or inserts: You pay nothing</p>
Diagnostic Tests, Lab and Radiology Services, and X-Rays (<i>Costs for these services may be different if received in an outpatient surgery setting</i>) ^{1,2}	<p>Diagnostic radiology services (such as MRIs, CT scans): You pay nothing</p> <p>Diagnostic tests and procedures: You pay nothing</p> <p>Lab services: You pay nothing</p> <p>Outpatient x-rays: You pay nothing</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing</p>
Doctor's Office Visits ^{1,2}	<p>Primary care physician visit: You pay nothing</p> <p>Specialist visit: You pay nothing</p>
Durable Medical Equipment (<i>wheelchairs, oxygen, etc.</i>) ¹	You pay nothing
Emergency Care	You pay nothing
Foot Care (<i>podiatry services</i>)	<p>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: You pay nothing</p> <p>Routine foot care (for up to 6 visit(s) every year): You pay nothing</p>

SECTION 2 (continued)

Hearing Services ^{1,2}	Exam to diagnose and treat hearing and balance issues: You pay nothing
Home Health Care ^{1,2}	You pay nothing
Mental Health Care ^{1,2}	<p>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.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>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.</p> <p>You pay nothing</p> <p>Outpatient group therapy visit: You pay nothing</p> <p>Outpatient individual therapy visit: You pay nothing</p>
Outpatient Rehabilitation ^{1,2}	<p>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</p> <p>Occupational therapy visit: You pay nothing</p> <p>Physical therapy and speech and language therapy visit: You pay nothing</p>
Outpatient Substance Abuse ^{1,2}	<p>Group therapy visit: You pay nothing</p> <p>Individual therapy visit: You pay nothing</p>
Outpatient Surgery ^{1,2}	<p>Ambulatory surgical center: You pay nothing</p> <p>Outpatient hospital: You pay nothing</p>
Over-the-Counter Items	<p>Please visit our website to see our list of covered over-the-counter items.</p> <ul style="list-style-type: none"> - You are eligible to receive a \$10 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 (<i>braces, artificial limbs, etc.</i>) ¹	<p>Prosthetic devices: You pay nothing</p> <p>Related medical supplies: You pay nothing</p>

SECTION 2 (continued)

Renal Dialysis ^{1,2}	You pay nothing
Transportation ¹	You pay nothing <ul style="list-style-type: none">- 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 ^{1,2}	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay nothing Eyeglasses or contact lenses after cataract surgery: You pay nothing
Preventive Care	You pay nothing <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none">• 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 <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p> <p>Annual physical exam: You pay nothing</p>
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.

SECTION 2 (continued)

INPATIENT CARE

Inpatient Hospital Care^{1,2}

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)^{1,2}

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 drugs¹: **You pay nothing**

Other Part B drugs¹: **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)	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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.

SECTION 2 (continued)

	<p>Tier 3 (Preferred Brand)</p>	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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.
	<p>Tier 4 (Non-Preferred Brand)</p>	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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.
	<p>Tier 5 (Specialty Tier)</p>	<ul style="list-style-type: none"> 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. 	<p>Not Offered</p>

SECTION 2 (continued)

Standard Mail Order Cost-Sharing		
Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	\$0	\$0
Tier 2 (Generic)	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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.

SECTION 2 (continued)

Tier 4 (Non-Preferred Brand)	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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

SECTION 2 (continued)

	<p>Tier 3 (Preferred Brand)</p>	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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.
	<p>Tier 4 (Non-Preferred Brand)</p>	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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.
	<p>Tier 5 (Specialty Tier)</p>	<ul style="list-style-type: none"> 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. 	<p>Not Offered</p>

SECTION 2 (continued)

	<p>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</p> <p>Days' Supply Available Unless otherwise specified, you can get your Part D medicine in the following days' supply:</p> <ul style="list-style-type: none">- One-month supply= up to 30 days*- Two-month supply= 31-60 days- Three-month supply= 61-90 days <p>*Long Term Care Pharmacy (one month supply= 31 days)</p>
Catastrophic Coverage	You pay nothing.

Additional Information About Humana Gold Plus SNP-DE H1036-239 (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 H1036-239 (HMO SNP) is a Coordinated Care plan with a Medicare contract and a contract with the North Carolina 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 H1036-239 (HMO SNP) may enroll dual eligibles who are SLMB Plus, 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 H1036-239 (HMO SNP)

Covered Medical and Hospital Benefits

Note:

- Humana Gold Plus SNP-DE H1036-239 (HMO SNP) services with a ¹ may require prior authorization.
- Humana Gold Plus SNP-DE H1036-239 (HMO SNP) services with a ² may require a referral from your doctor.

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H1036-239 (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. • 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	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: • \$2 copayment for Medicaid-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 Routine chiropractic visit (for up to 12 every year): You pay nothing

SECTION 4 (continued)

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H1036-239 (HMO SNP)
Dental Services	<p>For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.</p> <p>Medicaid usual limits and copayments for this service:</p> <ul style="list-style-type: none"> • \$3 copayment (only one copayment for services that require more than one visit) • Some services require prior approval 	<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing</p> <p>Preventive dental services: Cleaning (for up to 1 every year): You pay nothing</p> <p>Dental x-ray(s) (for up to 1 every year): You pay nothing</p> <p>Oral exam (for up to 1 every year): You pay nothing</p> <p>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.</p>
Diabetes Supplies and Services ^{1,2}	<p>For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copayments, and deductibles for Original Medicare covered services.</p>	<p>Diabetes monitoring supplies: You pay nothing</p> <p>Diabetes self-management training: You pay nothing</p> <p>Therapeutic shoes or inserts: You pay nothing</p>
Diagnostic Tests, Lab and Radiology Services, and X-Rays (<i>Costs for these services may be different if received in an outpatient surgery setting</i>) ^{1,2}	<p>For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.</p>	<p>Diagnostic radiology services (such as MRIs, CT scans): You pay nothing</p> <p>Diagnostic tests and procedures: You pay nothing</p> <p>Lab services: You pay nothing</p> <p>Outpatient x-rays: You pay nothing</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing</p>

SECTION 4 (continued)

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H1036-239 (HMO SNP)
Doctor's Office Visits ^{1,2}	<p>For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.</p> <p>Medicaid usual limits and copayments for this service:</p> <ul style="list-style-type: none"> • \$3 copayment per visit for Medicaid-covered services 	<p>Primary care physician visit: You pay nothing</p> <p>Specialist visit: You pay nothing</p>
Durable Medical Equipment (wheelchairs, oxygen, etc.) ¹	<p>For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.</p>	You pay nothing
Emergency Care	<p>For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.</p>	You pay nothing
Foot Care (podiatry services)	<p>For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.</p> <p>Medicaid usual limits and copayments for this service:</p> <ul style="list-style-type: none"> • \$3 copayment for Medicaid-covered services 	<p>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: You pay nothing</p> <p>Routine foot care (for up to 6 visit(s) every year): You pay nothing</p>
Hearing Services ^{1,2}	<p>For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.</p>	Exam to diagnose and treat hearing and balance issues: You pay nothing
Home Health Care ^{1,2}	<p>For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.</p>	You pay nothing

SECTION 4 (continued)

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H1036-239 (HMO SNP)
Mental Health Care ^{1,2}	<p>For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.</p> <p>Medicaid usual limits and copayments for this service</p> <ul style="list-style-type: none"> • \$3 copayment for Outpatient Medicaid-covered services 	<p>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.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>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.</p> <p>You pay nothing</p> <p>Outpatient group therapy visit: You pay nothing</p> <p>Outpatient individual therapy visit: You pay nothing</p>
Outpatient Rehabilitation ^{1,2}	<p>For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.</p>	<p>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</p> <p>Occupational therapy visit: You pay nothing</p> <p>Physical therapy and speech and language therapy visit: You pay nothing</p>

SECTION 4 (continued)

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H1036-239 (HMO SNP)
Outpatient Substance Abuse ^{1,2}	<p>For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.</p> <p>Medicaid usual limits and copayments for this service</p> <ul style="list-style-type: none"> • \$3 copayment for Medicaid-covered services 	<p>Group therapy visit: You pay nothing</p> <p>Individual therapy visit: You pay nothing</p>
Outpatient Surgery ^{1,2}	<p>For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.</p> <p>Medicaid usual limits and copayments for this service</p> <ul style="list-style-type: none"> • \$3 copayment for Medicaid-covered services 	<p>Ambulatory surgical center: You pay nothing</p> <p>Outpatient hospital: You pay nothing</p>
Over-the-Counter Items	<p>For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.</p> <p>Medicaid usual limits and copayments for this service:</p> <ul style="list-style-type: none"> • Certain OTC drugs are covered. 	<p>Please visit our website to see our list of covered over-the-counter items.</p> <ul style="list-style-type: none"> - You are eligible to receive a \$10 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 (<i>braces, artificial limbs, etc.</i>) ¹	<p>For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.</p> <p>Medicaid usual limits and copayments for this service:</p> <ul style="list-style-type: none"> • Prescription footwear coverage is limited to treatment of diabetics or when shoe is part of a leg brace (orthotic) or if there are foot complications in children under age 21. 	<p>Prosthetic devices: You pay nothing</p> <p>Related medical supplies: You pay nothing</p>

SECTION 4 (continued)

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H1036-239 (HMO SNP)
Renal Dialysis ^{1,2}	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. • \$0 copayment to Medicaid-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
Vision Services ^{1,2}	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: • \$3 copayment (Note: Effective 10-1-2011 non-covered for adults) • Visits are counted toward your 22 doctor visit limit per year	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay nothing Eyeglasses or contact lenses after cataract surgery: You pay nothing
Preventive Care	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: • \$3 copayment for mammograms, pap smears and pelvic exams	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

SECTION 4 (continued)

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H1036-239 (HMO SNP)
		<ul style="list-style-type: none"> • 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 <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p> <p>Annual physical exam: You pay nothing</p>
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.

SECTION 4 (continued)

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H1036-239 (HMO SNP)
<p>INPATIENT CARE Inpatient Hospital Care^{1,2}</p>	<p>For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.</p>	<p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <p>You pay nothing</p> <ul style="list-style-type: none"> • \$630 copay per day for days 91 through 150 • You pay nothing per day for days 151 and beyond
<p>Inpatient Mental Health Care</p>	<p>For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.</p>	<p>For inpatient mental health care, see the "Mental Health Care" section of this booklet</p>
<p>Skilled Nursing Facility (SNF)^{1,2}</p>	<p>For duals protected by the State Medicaid Program from cost-sharing, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.</p> <p>Medicaid usual limits and copayments for this service:</p> <ul style="list-style-type: none"> • Medicaid covers additional days beyond Medicare 100 day limit 	<p>Our plan covers up to 100 days in a SNF.</p> <p>You pay nothing</p>
Prescription Drug Benefits		
<p>Outpatient Prescription Drugs</p>	<p>Medicaid usual limits and copayments for this service:</p> <ul style="list-style-type: none"> • \$0.50 - \$3 copayment for Medicaid covered prescription drugs not covered by a Medicare Prescription Drug Plan. 	<p>For Part B drugs such as chemotherapy drugs¹: You pay nothing</p> <p>Other Part B drugs¹: You pay nothing.</p> <p>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.</p>

SECTION 4 (continued)

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 North Carolina Division of Medical Assistance 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: 1-800-662-7030.

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H1036-239 (HMO SNP)
PRODUCTS AND DEVICES		
Dentures	<ul style="list-style-type: none"> • \$0 copayment 	See Section 2 for more information regarding Humana Gold Plus Dental Services benefit.
Eyeglasses	<ul style="list-style-type: none"> • \$0 - no copayments for children • Contact lenses covered in special circumstances • Prior approval required for all visual aids • \$3 copayment for Medicaid vision services • \$2 copayment for optical repair over \$5 • \$2 copayment for optical supplies 	See Section 2 for more information regarding Humana Gold Plus Vision Services benefit.
Hearing Aids	<ul style="list-style-type: none"> • \$0 copayment • Under age 21 only • 1 monaural or binaural hearing aid covered with prior approval • Replacements based on medical necessity and require prior approval • Supplies related to hearing aid are covered with prior approval • Batteries are covered 	See Section 2 for more information regarding Humana Gold Plus Hearing Services benefit.
TRANSPORTATION		
Non-Emergency Medical Transportation Services	<ul style="list-style-type: none"> • \$0 copayment • Prior scheduling required 	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	<ul style="list-style-type: none"> • \$0 copayment 	Not covered.

SECTION 4 (continued)

Benefit	Medicaid State Plan	Humana Gold Plus SNP-DE H1036-239 (HMO SNP)
Inpatient Psychiatric Services, under age 21	• \$0 copayment	See Section 2 for more information regarding Humana Gold Plus Inpatient Mental Health benefit.
Intermediate Care Facility Services for the Mentally Retarded	• \$0 copayment	Not covered.
Nursing Facility Services, other than in an Institution for Mental Diseases	• \$0 copayment	See Section 2 for more information regarding Humana Gold Plus Skilled Nursing Facility benefit.

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 1-800-662-7030.

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 North Carolina Medicaid coverage information, please visit the North Carolina Medicaid website at <http://www.ncdhhs.gov/dma/medicaid/medicare.htm> or call the Medicaid Hotline at 1-800-662-7030.

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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 quý vị cần thông dịch viên xin gọi 1-800-457-4708. sẽ có nhân viên nói tiếng Việt giúp đỡ quý 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。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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