

2017 Summary of Benefits

Humana Gold Plus[®]
SNP-DE H1036-168 (HMO SNP)
Greensboro/Winston Salem
Greensboro / Winston-Salem Metro Area



Humana[®]

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Our service area includes the following county/counties in North Carolina: Alamance, Caswell, Davidson, Davie, Forsyth, Guilford, Person, Randolph, Rockingham, Stokes, Yadkin, NC;.



Monthly Premium, Deductible and Limits

Monthly premium	\$0
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	This plan does not have a deductible.
Maximum out-of-pocket responsibility	\$6,700 in-network The most you pay for copays, coinsurance and other costs for medical services for the year.



Covered Medical and Hospital Benefits

For members protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copays and deductibles for Original Medicare covered services.

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
ACUTE INPATIENT HOSPITAL CARE		
	\$0 copay	
DOCTOR OFFICE VISITS		
Primary care Physician (PCP)	\$0 copay	\$3 copay for Medicaid-covered services
Specialists	\$0 copay	\$3 copay for Medicaid-covered services
PREVENTIVE CARE		
Including: Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Any additional preventive services approved by Medicare during the contract year will be covered.	Covered at no cost when you see an in-network provider.	• \$3 copay for mammograms, pap smears and pelvic exams
EMERGENCY CARE		
Emergency room If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	\$0 copay	

Your plan may require approval in advance from your primary care physician (PCP) before you see a specialist or certain other providers. This is called a "referral." If you don't have a referral, you may have to pay for these services yourself.

Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."



Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
Urgently needed services Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	\$0 copay	
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic Mammography	\$0 copay	
Diagnostic radiology	\$0 copay	
Lab services	\$0 copay	
Diagnostic tests and procedures	\$0 copay	
Outpatient X-rays	\$0 copay	
Radiation Therapy	\$0 copay	
HEARING SERVICES		
Medicare covered hearing	\$0 copay	
Routine hearing	<ul style="list-style-type: none"> • \$0 copayment for fitting/evaluation, routine hearing test up to 1 per year. • \$1000 maximum benefit coverage amount per ear for Hearing Aids (all types) up to 1 per ear per year. 	

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Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
DENTAL SERVICES		
Medicare covered dental	\$0 copay	
Routine dental	<ul style="list-style-type: none"> • \$0 copayment for Periodic Oral Exam or Comprehensive Oral Evaluation, Prophylaxis (cleaning) up to 1 per year. • \$0 copayment for Bitewing X-rays up to 1 set(s) per year. • 50% coinsurance for Amalgam Filling, Periodontal Maintenance up to 1 per year. • 70% coinsurance for Scaling and Root Planing (Deep Cleaning) up to 1 per year. • \$0 copayment for Necessary Anesthesia with Covered Service up to unlimited per year. 	<ul style="list-style-type: none"> • \$3 copay (only one copay for services that require more than one visit) • Some services require prior approval
VISION SERVICES		
Medicare covered vision services	\$0 copay	<ul style="list-style-type: none"> • \$3 copay (Note: Effective 10-1-2011 non-covered for adults) • Visits are counted toward your 22 doctor visit limit per year
Glaucoma screening	\$0 copay	
Eyewear (post-cataract)	\$0 copay	
Routine vision	<ul style="list-style-type: none"> • \$0 copayment for Routine Exam, which includes refraction, up to 1 per year. • \$200 maximum benefit coverage amount per year for Contact Lenses or Eyeglasses - Lenses and Frames. • Includes ultraviolet protection and scratch resistant coating. 	

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Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	\$0 copay	<ul style="list-style-type: none"> • \$3 copay for Outpatient Medicaid-covered services
Outpatient group and individual therapy visits	\$0 copay	
SKILLED NURSING FACILITY		
Your plan covers up to 100 days in a SNF	\$0 copay	<ul style="list-style-type: none"> • Medicaid covers additional days beyond Medicare 100 day limit
REHABILITATION SERVICES		
Physical, occupational and speech therapy	\$0 copay	
Cardiac and pulmonary rehabilitation	\$0 copay	
AMBULANCE		
Ambulance (ground)	\$0 copay	
Ambulance (air)	\$0 copay	
TRANSPORTATION		
	\$0 copay for up to 24 one-way trips to plan approved locations. Not to exceed 25 miles per trip.	<ul style="list-style-type: none"> • \$0 copay to Medicaid-covered services
FOOT CARE (PODIATRY)		
Medicare covered foot care	\$0 copay	<ul style="list-style-type: none"> • \$3 copay for Medicaid-covered services
Routine foot care	0% per visit for up to 6 visits	
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	\$0 copay	
Medical Supplies	\$0 copay	
Prosthetics (artificial limbs or braces)	\$0 copay	<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

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Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
Diabetes monitoring supplies	\$0 copay	
FITNESS AND WELLNESS		
	SilverSneakers® Fitness Program - Basic fitness center membership including fitness classes.	
	The plan covers more benefits that promote health and well-being. To see more benefits, check out “More benefits with your plan,” listed later in this document.	



Prescription Drug Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
MEDICARE PART B DRUGS		
Chemotherapy drugs	\$0 copay	
Other part B drugs	\$0 copay	
PRESCRIPTION DRUGS		
Medicare Part D Drugs	See chart below for plan coverage information for prescription drugs	<p>Medicaid may cover some drugs that are not covered by Part D. Contact your Medicaid agency for questions on drug coverage.</p> <ul style="list-style-type: none"> • \$0.50 - \$3 copay for Medicaid covered prescription drugs not covered by a Medicare Prescription Drug Plan.

Initial coverage (after you pay your deductible, if applicable)

30-day supply

For generic drugs (including brand drugs treated as generic), either:	\$0 copay; or \$1.20 copay; or \$3.30 copay
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For all other drugs, either:	\$0 copay; or \$3.70 copay; or \$8.25 copay
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90-day supply

For generic drugs (including brand drugs treated as generic), either:	\$0 copay; or \$1.20 copay; or \$3.30 copay
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Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called “prior authorization” or “preauthorization.”

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
For all other drugs, either:	\$0 copay; or \$3.70 copay; or \$8.25 copay	

Specialty drugs are limited to a 30 day supply.

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

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

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

Days’ Supply Available

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

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

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

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **\$4,950**, you pay nothing for all drugs.

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.

BENEFITS	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID STATE PLAN
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PRODUCTS AND DEVICES

Dentures	See “Dental” benefit in the “Covered Medical and Hospital Benefits” chart above	• \$0 copay
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Eyeglasses	See “Vision” benefit in the “Covered Medical and Hospital Benefits” chart above	<ul style="list-style-type: none"> • \$0 - no copays for children • Contact lenses covered in special circumstances • Prior approval required for all visual aids • \$3 copay for Medicaid vision services • \$2 copay for optical repair over \$5 • \$2 copay for optical supplies
Hearing Aids	See “Hearing” benefit in the “Covered Medical and Hospital Benefits” chart above	<ul style="list-style-type: none"> • \$0 copay • 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
TRANSPORTATION		
Non-Emergency Medical Transportation Services	See “Transportation” benefit in the “Covered Medical and Hospital Benefits” chart above	<ul style="list-style-type: none"> • \$0 copay • Prior scheduling required
INPATIENT LONG TERM CARE SERVICES		
Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services in Institutions for Mental Diseases (IMD), age 65 and older	Not covered	<ul style="list-style-type: none"> • \$0 copay
Inpatient Psychiatric Services, under age 21	See “Mental Health” benefit in the “Covered Medical and Hospital Benefits” chart above	<ul style="list-style-type: none"> • \$0 copay
Intermediate Care Facility Services for the Mentally Retarded	Not Covered	<ul style="list-style-type: none"> • \$0 copay
Nursing Facility Services, other than in an Institution for Mental Diseases	See “Skilled Nursing” benefit in the “Covered Medical and Hospital Benefits” chart above	<ul style="list-style-type: none"> • \$0 copay
Other Medicaid Covered Services		
Outpatient Surgery	\$0 copay	<ul style="list-style-type: none"> • \$3 copay for Medicaid-covered services

Over-the-Counter (OTC) benefit	See “Over-the-Counter benefits” on the “More benefits with your plan” page later in this document	• Certain OTC drugs are covered.
Chiropractic Services	Medicare-covered Chiropractic Services: \$0 copay	• \$2 copay for Medicaid-covered services

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 7/1/2016. 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.



More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

Acupuncture

\$0 copay per visit for 6 visits every 12 months

Additional smoking cessation

A smoking cessation program available on-line, email and phone. Personal coaches assist via establishing goals and providing articles and resources to aid in the effort to quit smoking.

Chiropractic services

Medicare-covered Chiropractic Services:

\$0 copay

Routine Chiropractic Services:

- **0%** per visit for up to 12 visits

Counseling

Member Assistance Program includes counseling by phone to help you cope with life changes, including adult care and child care issues. Online resources are also available.

Enhanced nutrition therapy

Additional one-on-one nutrition therapy counseling.

Health education

One-on-one wellness coaching with email, phone and online chat options.

Meals

Well Dine Meal Program - Humana's meal program for members with certain special needs plan (SNP) specific conditions or following an inpatient stay in the hospital or nursing facility

HumanaFirst nurse advice line

Health advice from a registered nurse, available 24 hours a day, seven days a week.

Over-the-counter allowance

\$0 copay; up to **\$15** monthly value for the purchase of OTC supplies from Humana Pharmacy mail delivery.

Weight management program

Weekly one-on-one consultations to talk through challenges of losing and/or managing weight, get support toward weight loss goals and celebrate success.

Wigs

Wigs for hair loss related to chemotherapy.

Go365™ by Humana

Rewards for completing preventive health screenings and activities.



Find out **more**



You can see our plan's **provider and pharmacy directory** at our website at **www.humana.com/members/tools** 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 formulary** at our website at **www.humana.com/medicare/medicare_prescription_drugs/medicare_drug_tools/medicare_drug_list/** or call us at the number listed at the beginning of this booklet and we will send you one.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

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 12/31/2018 based on a review of Humana's Model of Care.

Premiums, co-pays, co-insurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for more details.

The provider/pharmacy network may change at any time. You will receive notice when necessary.

Discrimination is Against the Law

CHA HMO, INC., CAREPLUS HEALTH PLANS, INC., HUMANA MEDICAL PLAN, INC, HUMANA HEALTH PLAN, INC., HUMANA BENEFIT PLAN OF ILLINOIS, INC., HUMANA INSURANCE COMPANY, HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC., HUMANA INSURANCE OF PUERTO RICO, INC., HUMANA MEDICAL PLAN OF UTAH, INC., HUMANA HEALTH COMPANY OF NEW YORK, INC., HUMANA HEALTH PLANS OF PUERTO RICO, INC., HUMANA EMPLOYERS HEALTH PLAN OF GEORGIA, INC., HUMANA REGIONAL HEALTH PLAN, INC. CARITEN HEALTH PLAN INC., HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC., ARCADIAN HEALTH PLAN, INC., HUMANA INSURANCE COMPANY OF NEW YORK, HUMANA WI HEALTH ORGANIZATION INSURANCE CORP, HUMANA MEDICAL PLAN OF PENNSYLVANIA, INC., HUMANA MEDICAL PLAN OF MICHIGAN, INC. (“Humana”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats
- Provides free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Dr. Michelle Griffin, PhD.

If you believe that Humana has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Dr. Michelle M. Griffin, PhD (FACHE)

Civil Rights/LEP/ADA/Section 1557 Compliance Officer: 500 W. Main Street -10th floor Louisville, Kentucky 40202 Phone: 1-877-320-1235 Fax: 877-320-1269

Email: Mgriffin5@humana.com or Accessibility@humana.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Dr. Michelle Griffin PHD, Civil Rights/LEP/ADA/Section 1557 Compliance Officer is available to help you at the contact information listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Multi-Language Interpreter Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-457-4708 (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-457-4708 (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-457-4708 (TTY: 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-457-4708 (TTY: 711).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-800-457-4708 (TTY: 711)번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-457-4708 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-457-4708 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-457-4708 (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-457-4708 (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-457-4708 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-457-4708 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-457-4708 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-457-4708 (TTY: 711).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-457-4708 (TTY: 711) まで、お電話にてご連絡ください。

فارسی (Farsi):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-457-4708 (رقم هاتف الصم والبكم: 711).

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-800-457-4708 (TTY: 711)

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-457-4708 (رقم هاتف الصم والبكم: 711).

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Area



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