2023

Summary of Benefits

HumanaChoice Florida SNP-DE H7284-010 (PPO D-SNP)

Southeast Florida

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Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-833-2364 (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 **1-800-833-2364 (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

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you may pay a higher co-pay for services received by non-contracted providers.
- ☐ 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. This plan may enroll FBDE, QDWI, QI, QMB, QMB+, SLMB, SLMB+.

2023

Summary of Benefits

HumanaChoice Florida SNP-DE H7284-010 (PPO D-SNP)

Southeast Florida

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Our service area includes the following county/counties in Florida: Brevard, Broward, Glades, Indian River, Martin, Miami-Dade, Okeechobee, Palm Beach, St. Lucie.

Let's talk about HumanaChoice Florida SNP-DE H7284-010 (PPO D-SNP)

Find out more about the HumanaChoice Florida SNP-DE H7284-010 (PPO D-SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice Florida SNP-DE H7284-010 (PPO D-SNP) is a Coordinated Care plan LPPO with a Medicare contract and a contract with the Florida Medicaid program. Enrollment in this Humana plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, ask us for the "Evidence of Coverage".

As a member, it's a good idea to select a doctor as your Primary Care Provider(PCP). HumanaChoice Florida SNP-DE H7284-010 (PPO D-SNP) has a network of doctors, hospitals, pharmacies and other providers. 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 HumanaChoice Florida SNP-DE H7284-010 (PPO 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 Florida Medicaid. If you receive both Medicare and Medicaid benefits, this means you are dual eligible.

HumanaChoice Florida SNP-DE H7284-010 (PPO D-SNP) may enroll FBDE, QDWI, QI, QMB, QMB+, SLMB, SLMB+.

Qualified Medicare Beneficiary (QMB): Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).

Qualified Medicare Beneficiary Plus (QMB+): Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

Specified Low-Income Medicare Beneficiary (SLMB): Helps pay Part B premiums.

Specified Low-Income Medicare Beneficiary Plus (SLMB+): Helps pay Part B premiums and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

Full Benefit Dual Eligible (FBDE): Financial assistance may be available to pay Medicare Part A Premiums, and/or Medicare Part B Premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) and provides full Medicaid benefits.

Qualifying Individual (QI): Helps pay Part B premiums.

Qualified Disabled and Working Individual (QDWI): Helps pay Part A premiums.

Plan name:

HumanaChoice Florida SNP-DE H7284-010 (PPO D-SNP)

More about HumanaChoice Florida SNP-DE H7284-010 (PPO D-SNP)

Depending on your level of eligibility for assistance under your state Medicaid program, you may or may not be subject to cost-sharing requirements. The Medicaid Comparison Chart shows specific benefits that Medicaid may cover for some dual eligible members. You will work with your Humana care coordinator to understand and access these benefits from the Florida Medicaid after any HumanaChoice Florida SNP-DE H7284-010 (PPO D-SNP) benefits are used. The Covered Medical and Hospital Benefits chart shows the benefits you will receive from Humana.

Be sure to show the Florida 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 Florida Medicaid for further details.

If you're a member of this plan, call toll-free: **1-800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-833-2364 (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 07/01/2022 and are subject to change.

For the most current Florida Medicaid coverage information, please visit the Florida Medicaid website at **https://ahca.myflorida.com/Medicaid/index.shtml** or call the Medicaid Hotline at 1-888-419-3456 (TTY: 711).

A healthy partnership

Get more from your plan — with extra services and resources provided by Humana!

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Monthly Premium, Deductible and Limits

Monthly plan premium	**$0** or up to **$35.90** depending on your level of "Extra Help" You must keep paying your Medicare Part B premium. Your Part A and/or Part B premium may be paid on your behalf by the Florida Medicaid Program.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	**$0** if you qualify for "Extra Help"
Maximum out-of-pocket responsibility	**$5,000** in-network **$8,950** combined in- and out-of-network The most you pay for copays, coinsurance and other costs for covered medical services for the year.

Covered Medical and Hospital Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN IN-NETWORK	**WHAT YOU PAY ON THIS HUMANA PLAN OUT-OF-NETWORK**
ACUTE INPATIENT HOSPITAL CARE		
	$0 or **$1,000** copay per admit	**$0** or **40%** of the cost
OUTPATIENT HOSPITAL COVERAGE		
Outpatient surgery at outpatient hospital	**$0** or **20%** of the cost	**$0** or **40%** of the cost
Outpatient surgery at ambulatory surgical center	**$0** or **20%** of the cost	**$0** or **40%** of the cost
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**$0** or **40%** of the cost
Specialists	**$0** copay	**$0** or **40%** of the cost
PREVENTIVE CARE		
	Our plan covers many preventive services at no cost including: • Abdominal aortic aneurysm Screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy)	**$0** copay or **40%** of the cost, depending on the service and where service is provided Any additional preventive services approved by Medicare during the contract year will be covered.

You do not need a referral to receive covered services from plan providers. 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 prior authorization from the plan.

	WHAT YOU PAY ON THIS HUMANA PLAN IN-NETWORK	WHAT YOU PAY ON THIS HUMANA PLAN OUT-OF-NETWORK
	• 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) • Annual Wellness Visit • Lung cancer screening • Routine physical exam • Medicare diabetes prevention program Any additional preventive services approved by Medicare during the contract year will be covered.	
EMERGENCY CARE		
Emergency room If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	**$0** or **$90** copay	**$0** or **$90** copay

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Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN IN-NETWORK	WHAT YOU PAY ON THIS HUMANA PLAN OUT-OF-NETWORK
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** or **$60** copay at an urgent care center	**$0** or **$60** copay at an urgent care center
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic mammography	**$0** copay	**$0** or **40%** of the cost
Diagnostic colonoscopy	**$0** copay	**$0** or **40%** of the cost
Diagnostic radiology	**$0** copay or **20%** of the cost	**$0** or **40%** of the cost
Lab services	**$0** to **$60** copay or **20%** of the cost	**$0** copay or **40%** of the cost
Diagnostic tests and procedures	**$0** to **$60** copay or **20%** of the cost	**$0** or **40%** of the cost
Outpatient X-rays	**$0** to **$60** copay or **20%** of the cost	**$0** or **40%** of the cost
Radiation therapy	**$0** copay or **20%** of the cost	**$0** or **40%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**$0** copay	**$0** or **40%** of the cost
Routine hearing The provider location for routine hearing can be found at **Humana.com** > Find a doctor > Medical > Enter Zip Code > Select look up method > Select Medicare > Select Network (your plan's Name) > Select > Select Category "Name" > HearUSA > Search > HearUSA provider appears.	**HER835** • **$0** copay for fitting/evaluation, routine hearing exams up to 1 per year. • **$3,600** combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 every 3 years.	**HER835** • **25%** of the cost for hearing aids (all types) up to 2 every 3 years. • **25%** of the cost for fitting/evaluation, routine hearing exams up to 1 per year. • **$3,600** combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 every 3 years. • Benefits received out-of-network are subject to a **25%** deduction from the combined maximum benefit coverage reimbursement in

You do not need a referral to receive covered services from plan providers. 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 prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN IN-NETWORK	WHAT YOU PAY ON THIS HUMANA PLAN OUT-OF-NETWORK
		addition to any in-network benefit maximums, limitation, and/or exclusions.
DENTAL SERVICES		
Medicare-covered dental	**$0** copay	**$0** or **40%** of the cost
Routine dental Dental services are subject to our standard claims review procedures which could include dental history to approve coverage. Dental benefits under this plan may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**. Out-of-network dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefits maximums, limitations, and/or exclusions. You may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Use the Florida GoldPlus Dental network for the Mandatory Supplemental Dental. The provider locator can be found at **Humana.com** > Find a Doctor > from the Search Type drop down select Dental > under Coverage Type select All Dental Networks > enter zip code > from the	**DEN145** • **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. • **$0** copay for bridges, complete dentures, crown recementation, denture recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years. • **$0** copay for crown, root canal, root canal retreatment up to 1 per tooth per lifetime. • **$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • **$0** copay for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year. • **$0** copay for emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.	**DEN145** • **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. • **$0** copay for bridges, complete dentures, crown recementation, denture recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years. • **$0** copay for crown, root canal, root canal retreatment up to 1 per tooth per lifetime. • **$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • **$0** copay for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year. • **$0** copay for emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.

You do not need a referral to receive covered services from plan providers. 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 prior authorization from the plan.

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Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN IN-NETWORK	WHAT YOU PAY ON THIS HUMANA PLAN OUT-OF-NETWORK
network drop down select Florida GoldPlus Dental.	• **$0** copay for periodontal maintenance up to 4 per year. • **$0** copay for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. • **$5000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits.	• **$0** copay for periodontal maintenance up to 4 per year. • **$0** copay for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. • **$5000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
VISION SERVICES		
Medicare-covered vision services	**$0** copay	**$0** or **40%** of the cost
Medicare-covered diabetic eye exam	**$0** copay	**$0** or **40%** of the cost
Medicare-covered glaucoma screening	**$0** copay	**$0** or **40%** of the cost
Medicare-covered eyewear (post-cataract)	**$0** copay	**$0** copay
Routine vision The provider locator for routine vision can be found at **Humana.com** > Find a Doctor > select Vision care icon > Vision coverage through Medicare Advantage plans.	**VIS703** • **$0** copay for routine exam up to 1 per year. • **$40** combined maximum benefit coverage amount per year for routine exam. • **$400** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.	**VIS703** • **$0** copay for routine exam up to 1 per year. • **$40** combined maximum benefit coverage amount per year for routine exam. • **$400** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.

You do not need a referral to receive covered services from plan providers. 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 prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN IN-NETWORK	WHAT YOU PAY ON THIS HUMANA PLAN OUT-OF-NETWORK
	• Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year.	• Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$0** or **$1,000** copay per admit	**$0** or **40%** of the cost
Outpatient group and individual therapy visits	**$0** to **$55** copay or **20%** of the cost	**$0** or **40%** of the cost
SKILLED NURSING FACILITY (SNF)		
Your plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$0** or **$185.50** copay per day for days 21-100	**$0** or **40%** of the cost for days 1-100
PHYSICAL THERAPY		
	$0 copay or **20%** of the cost	**$0** or **40%** of the cost
AMBULANCE		
Ambulance	**$0** or **20%** of the cost	**$0** or **20%** of the cost

You do not need a referral to receive covered services from plan providers. 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 prior authorization from the plan.

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Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN IN-NETWORK	WHAT YOU PAY ON THIS HUMANA PLAN OUT-OF-NETWORK
TRANSPORTATION		
	$0 copay for plan approved location up to unlimited one-way trip(s) per year. The member *must* contact transportation vendor to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider.	
MEDICARE PART B DRUGS		
Chemotherapy drugs	**$0** copay or **20%** of the cost	**$0** copay or **40%** of the cost
Other Part B drugs	**$0** or **20%** of the cost	**$0** or **40%** of the cost

Prescription Drug Benefits

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

$0 Rx Copay Benefit If you qualify for "Extra Help", you will pay **$0** for all Medicare Part D covered prescription drugs on your formulary, for all tiers, and through all stages. If you do not receive "Extra Help" refer to Chapter 6 of the Evidence of Coverage for more details on the prescription drug benefit.

You do not need a referral to receive covered services from plan providers. 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 prior authorization from the plan.

Pharmacy options		
Mail Order	**Mail Order cost-sharing** **$0**	CenterWell Pharmacy™, Walmart Mail, PillPack Other pharmacies are available in our network. To find pharmacy mail order options go to **Humana.com/pharmacyfinder**
Retail	**Retail cost-sharing**	All network retail pharmacies
For generic drugs (including brand drugs treated as generic), either:	**30-day supply** **$0**	**90-day supply*** **$0**
For all other drugs, either:	**$0**	**$0**

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

To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 Monday — Friday, 7 a.m. — 7 p.m. TTY users should call 1-800-325-0778. For more information on pharmacy-specific cost-sharing, please call us or refer to Chapter 6 of the Evidence of Coverage for more details.

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

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

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,400**, your share of the cost for a covered drug will be either:

- **$0** or **$4.15** for generic (including brand drugs treated as generic) and a **$0** or **$10.35** copay for all other drugs

Additional Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN IN-NETWORK	WHAT YOU PAY ON THIS HUMANA PLAN OUT-OF-NETWORK
Medicare-covered foot care (podiatry)	**$0** copay	**$0** or **40%** of the cost
Medicare-covered chiropractic services	**$0** copay	**$0** or **40%** of the cost
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**$0** or **20%** of the cost	**$0** or **40%** of the cost

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	WHAT YOU PAY ON THIS HUMANA PLAN IN-NETWORK	WHAT YOU PAY ON THIS HUMANA PLAN OUT-OF-NETWORK
Medical Supplies	**$0** or **20%** of the cost	**$0** or **40%** of the cost
Prosthetics (artificial limbs or braces)	**$0** or **20%** of the cost	**$0** or **40%** of the cost
Diabetic monitoring supplies	**$0** copay	**$0** copay or **40%** of the cost
REHABILITATION SERVICES		
Occupational and speech therapy	**$0** copay or **20%** of the cost	**$0** or **40%** of the cost
Cardiac rehabilitation	**$0** copay or **20%** of the cost	**$0** or **40%** of the cost
Pulmonary rehabilitation	**$0** copay or **20%** of the cost	**$0** or **40%** of the cost
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	**Not Covered**
Specialist	**$0** copay	**Not Covered**
Urgent care services	**$0** copay	**Not Covered**
Substance abuse or behavioral health services	**$0** copay	**Not Covered**

Medicaid Benefit Comparison

The benefits described in the Covered Medical and Hospital Benefits sections above are covered by HumanaChoice Florida SNP-DE H7284-010 (PPO D-SNP). Below is a comparison of benefits that some Medicaid eligible individuals could receive directly from the Florida Medicaid. For each benefit listed below, you can see what the Florida Medicaid covers and what our plan covers. All Medicaid benefits are subject to Medicaid eligibility guidelines and requirements, and are available only to full dual eligible individuals. If you have questions about your Medicaid eligibility and what benefits you are entitled to, review your member handbook or contact the Florida Medicaid at 1-888-419-3456.

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Acute inpatient hospital care	Covered	Covered
Ambulance	Covered	Covered
Ambulatory surgical center	Covered	Covered
Dentures	Covered	Covered
Diagnostic services/labs/imaging	Covered	Covered
Doctor office visits (Primary care provider (PCP)/specialists	Covered	Covered

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Emergency care	Covered	Covered
Eyeglasses	Covered	Covered
Hearing aids	Covered	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 psychiatric services, under age 21	Covered	Covered with limitations
Intermediate care facility for intellectual disabilities (ICF-IDD)	Covered	Not Covered
Intermediate care facility services for individuals with intellectual disabilities	Covered	Covered with limitations
Mental health services (outpatient group therapy and individual therapy visit)	Covered	Covered
Nursing facility services, other than in an institution for mental diseases	Covered	Covered with limitations
Outpatient hospital coverage	Covered	Covered
Personal emergency response system (PERS)	Not Covered	Covered
Physical therapy	Covered	Covered
Prescription drugs – Medicare Part B drugs	Covered	Covered
Prescription drugs – outpatient prescription drugs; Medicare covered & non-Medicare covered	Covered	Covered
Preventive care (e.g., flu vaccine, diabetic screenings)	Covered	Covered
Routine non-emergency medical transportation	Covered	Covered

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Skilled nursing facility	Covered	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/medicare** to view a copy of the EOC or call **1-800-833-2364**.

Humana Healthy Options Allowance

$150 automatically loaded on a prepaid card every month to use toward the purchase of food, over-the-counter (OTC) products, and home supplies from a national network of retailers. The card may also be used to pay for non-medical transportation, general supports for living (such as rent assistance, internet, and utilities), social needs, aging support and assistive devices, pest control, and pet care and supplies. Unused amount expires at the end of the month. Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

Humana Spending Account Card

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

*Healthy Options Allowance

Travel Coverage

The PPO national network gives you in-network coverage across the country, so you can see any doctor who accepts the plan terms and conditions. You'll be able to travel with ease or split your time between locations. Visit **Humana.com** or contact Customer Care on the back of your ID card if you need help finding an in-network provider.

Acupuncture

$0 copay for acupuncture visits up to 25 visit(s) per year.

Authorization rules may apply

Smoking cessation program

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

Routine foot care

- In-network: **$0** copay
- Out-of-network: **40%** of the cost
- Combined in- and out-of-network visit limit: 12 visits per year.

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Papa Pals
$0 copayment for members to be connected with a trusted college student that offers assistance with other instrumental activities of daily living (IADLs). Support may be in person or virtually for up to 60 hours per year (minimum of one hour per visit).

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

Personal Emergency Response System
The personal emergency response system provides help in emergency situations. The medical alert service comes with an installed in-home communication device and a wearable button. You have the choice between a push button unit (with or without AutoAlert fall detection) or a wrist unit (without AutoAlert).

Post Discharge Personal Home Care
$0 copayment for a minimum of 4 hours per day, up to a maximum of 28 hours per year for certain in-home support services following a discharge from a skilled nursing facility or from an inpatient hospitalization. Services must be initiated within 30 days of discharge event and utilized within 60 days of discharge for each qualifying event up to the maximum annual allowance.

Authorization may be required. Contact the plan for details.

Rewards and Incentives
Go365 by Humana® a Rewards and Incentive program for completing certain preventive health screenings and health and wellness activities.

Wigs (related to chemotherapy treatment)
Up to a **$500** combined in and out of network maximum benefit per year.

SilverSneakers® fitness program
Basic fitness center membership including fitness classes.

Find out **more**

You can see our plan's **provider and pharmacy directory** at our website at **humana.com/finder/search** or call us at the number listed at the beginning of this booklet and we will send you one.

You can see our plan's **drug guide** at our website at **humana.com/medicaredruglist** or call us at the number listed at the beginning of this booklet and we will send you one.

To find out more about the coverage and costs of Original Medicare, look in the current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Humana has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2025 based on a review of Humana's Model of Care.

Sponsored by HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC and the State of Florida, Agency For Health Care Administration.

If you are cost-share protected by the Florida Medicaid, HumanaChoice Florida SNP-DE H7284-010 (PPO D-SNP) providers aren't allowed to collect or bill you for services and items covered under Medicare Part A and Part B, including deductibles, coinsurance, and copayments – even when Medicaid payment is zero or a provider chooses to not submit to Medicaid. If a provider asks you to pay, that's against the law. You may however be responsible for a small Medicaid copayment.

If you are cost-share protected and you are billed or asked to pay the provider for deductibles, coinsurance, or copayments on covered Medicare Part A and Part B services tell your provider you are cost-share protected and can't be charged. If you have already made payment you have the right to a refund. If your provider will not stop billing, you can call us at 1-800-457-4708 or you can call Medicare at 1-800-Medicare (1-800-633-4227), (TTY 1-877-486-2048). Humana or Medicare can ask your provider to stop billing you and refund any payment you have made.

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.

Out-of-network/non-contracted providers are under no obligation to treat Humana members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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Notes

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 **1-877-320-1235** 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. 1-877-320-1235 (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 1-877-320-1235 (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 1-877-320-1235 (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 1-877-320-1235 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-320-1235 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (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 1-877-320-1235 (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 1-877-320-1235 (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 1-877-320-1235 (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 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

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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 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-320-1235 (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 1-877-320-1235 (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 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugues: 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 1-877-320-1235 (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 1-877-320-1235 (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 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康健康保険と薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-877-320-1235 (TTY: 711) にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

HumanaChoice Florida SNP-DE
H7284-010 (PPO D-SNP)
H7284010000 ENG
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