2025

Summary of Benefits

HumanaChoice SNP-DE H7284-003 (PPO D-SNP)

This is a Highly Integrated Dual Eligible (HIDE) Special Needs Plan.

Greater North Florida PPO

Panhandle

Our service area includes the following county/counties in Florida: Bradford, Calhoun, Dixie, Franklin, Gadsden, Gilchrist, Gulf, Hamilton, Holmes, Jackson, Jefferson, Lafayette, Levy, Liberty, Madison, Suwannee, Union, Wakulla, Washington.

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. The Part A/ Part B premiums may be paid for by Florida Medicaid.
- ☐ Benefits, premiums and/or copays/coinsurance may change on January 1, 2026.
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ This 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 situation, non-contracted providers may deny care. In addition, you may pay a higher copay/coinsurance 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, QMB+, SLMB+.

Humana.

Let's talk about HumanaChoice SNP-DE H7284-003 (PPO D-SNP)

Find out more about the HumanaChoice SNP-DE H7284-003 (PPO D-SNP) plan – including the health and drug services it covers – in this easy-to-use guide.

HumanaChoice SNP-DE H7284-003 (PPO D-SNP) is a Coordinated Care plan LPPO with a Medicare contract and a contract with 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, please refer to the plan's Evidence of Coverage on our website, **Humana.com/PlanDocuments**.

As a member, it's a good idea to select a doctor as your Primary Care Provider(PCP). HumanaChoice SNP-DE H7284-003 (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

If you receive both Medicare and Medicaid benefits, this means you are dual eligible. To enroll in HumanaChoice SNP-DE H7284-003 (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 Florida Medicaid.

HumanaChoice SNP-DE H7284-003 (PPO D-SNP) may enroll FBDE, QMB+, SLMB+.

Full Benefit Dual Eligible (FBDE): May help pay Medicare Part A and/or Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

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 Plus (SLMB+): Helps pay Part B premiums and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

Plan name

HumanaChoice SNP-DE H7284-003 (PPO D-SNP)

More about HumanaChoice SNP-DE H7284-003 (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 Benefit 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. 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 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 07/01/2024 and are subject to change. For the most current Florida Medicaid coverage information, please visit Florida Medicaid website at **https://ahca.myflorida.com** or call the Medicaid Hotline at 1-888-419-3456 (toll free) 1-800-955-8771 (TTY).

A healthy partnership

Get more from this plan – with extra services and resources provided by Humana!

Humana.

Monthly Premium, Deductible and Limits

Monthly plan premium	**$0** You must keep paying your Medicare Part B premium. Your Part A and/or Part B premium may be paid on your behalf by Florida Medicaid Program.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	**$590** deductible
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for covered medical services for the year	**$6,425** in-network **$10,000** combined in- and out-of-network If you are eligible for Medicare cost-sharing assistance under Florida Medicaid you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Medical Benefits

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
INPATIENT HOSPITAL COVERAGE		
This plan covers an unlimited number of days for an inpatient stay.	**$0** copay	**$0** or **40%** of the cost
OUTPATIENT HOSPITAL COVERAGE		
Diagnostic colonoscopy	**$0** copay	**$0** or **40%** of the cost
Diagnostic mammography	**$0** copay	**$0** or **40%** of the cost
Surgery services	**$0** copay	**$0** or **40%** of the cost
AMBULATORY SURGERY CENTER		
Diagnostic colonoscopy	**$0** copay	**$0** or **40%** of the cost
Surgery services	**$0** copay	**$0** or **40%** of the cost
DOCTOR VISITS		
Primary care provider (PCP)		
• PCP's office	**$0** copay	**$0** or **40%** of the cost
• Telehealth	**$0** copay	**Not Covered**
Specialist		
• Specialist's office	**$0** copay	**$0** or **40%** of the cost
• Telehealth	**$0** copay	**Not Covered**

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

Medical Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
PREVENTIVE CARE		
This plan covers all Medicare preventive services including: • **Abdominal aortic aneurysm screening** • **Alcohol misuse screening & counseling** • **Annual Wellness Visit (AWV)** • **Bone mass measurement** • **Breast cancer screening (mammogram)** • **Cardiovascular disease risk reduction visit** • **Cardiovascular disease screenings** • **Cervical and vaginal cancer screening** • **Colorectal cancer screening** • **Depression screening** • **Diabetes screening** • **Diabetes self-management training** • **Glaucoma screening** • **HIV screening** • **Immunizations** • **Lung cancer screening** • **Medical nutrition therapy** • **Medicare Diabetes Prevention Program (MDPP)** • **Obesity screening and therapy** • **Prostate cancer screening exams** • **Routine physical Exam** • **Sexually transmitted infections (STIs) screening and counseling** • **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)** • **"Welcome to Medicare"**	**$0** copay	**$0** copay or **50%** of the cost, depending on the service and where service is provided

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

Humana.

Medical Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
preventive visit Any additional preventive services approved by Medicare during the contract year will be covered.		
EMERGENCY CARE		
Emergency room If you are admitted to the same hospital within 24 hours, you do not have to pay your share of the cost for the emergency care. When placed in observation, member pays observation cost-share instead of emergency room cost-share.	**$0** copay	**$0** or **$125** copay
Physician and professional services at emergency room	**$0** copay	**$0** copay
URGENTLY NEEDED SERVICES		
• **Telehealth** • **Urgent care center** Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$0** copay **$0** copay	**Not Covered** **$0** or **20%** of the cost
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Advanced imaging services (MRI, MRA, PET and CT scan)		
• Freestanding radiological facility	**$0** copay	**$0** or **40%** of the cost
• Outpatient hospital	**$0** copay	**$0** or **40%** of the cost
• PCP's office	**$0** copay	**$0** or **40%** of the cost
• Specialist's office	**$0** copay	**$0** or **40%** 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 this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

Medical Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
Basic radiological services (X-rays)		
• Freestanding radiological facility	**$0** copay	**$0** or **40%** of the cost
• Outpatient hospital	**$0** copay	**$0** or **40%** of the cost
• PCP's office	**$0** copay	**$0** or **40%** of the cost
• Specialist's office	**$0** copay	**$0** or **40%** of the cost
• Urgent care center	**$0** copay	**$0** or **40%** of the cost
Diagnostic mammography		
• Freestanding radiological facility	**$0** copay	**$0** or **40%** of the cost
• Specialist's office	**$0** copay	**$0** or **40%** of the cost
Diagnostic procedures and tests		
• Outpatient hospital	**$0** copay	**$0** or **40%** of the cost
• PCP's office	**$0** copay	**$0** or **40%** of the cost
• Specialist's office	**$0** copay	**$0** or **40%** of the cost
• Urgent care center	**$0** copay	**$0** or **40%** of the cost
Lab services		
• Freestanding laboratory	**$0** copay	**$0** or **40%** of the cost
• Outpatient hospital	**$0** copay	**$0** or **40%** of the cost
• PCP's office	**$0** copay	**$0** or **40%** of the cost
• Specialist's office	**$0** copay	**$0** or **40%** of the cost
• Urgent care center	**$0** copay	**$0** or **40%** of the cost
Nuclear medicine and services		
• Freestanding radiological facility	**$0** copay	**$0** or **40%** of the cost
• Outpatient hospital	**$0** copay	**$0** or **40%** of the cost
Sleep study		
• Member's home	**$0** copay	**$0** or **40%** of the cost
• Outpatient hospital	**$0** copay	**$0** or **40%** of the cost
• Specialist's office	**$0** copay	**$0** or **40%** of the cost
Therapeutic radiology (Radiation therapy)		
• Freestanding radiological facility	**$0** copay	**$0** or **40%** of the cost
• Outpatient hospital	**$0** copay	**$0** or **40%** of the cost
• Specialist's office	**$0** copay	**$0** or **40%** 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 this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

Humana.

Medical Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
HEARING SERVICES		
Medicare-covered hearing	**$0** copay	**$0** or **40%** of the cost
Mandatory supplemental hearing benefit The provider locator for mandatory supplemental hearing benefits can be found at **Humana.com** > Find Care.	**HER833** • **$0** copay for fitting/evaluation, routine hearing exams up to 1 per year. • **$1,000** combined maximum benefit coverage amount for both OTC hearing aids, prescription hearing aids (all types) up to 2 every 3 years.	**HER833** • **25%** of the cost for fitting/evaluation, routine hearing exams up to 1 per year. • **$1,000** combined allowance amount with a **25%** reduction for out of network (**$750** out of network allowance) for both OTC hearing aids, prescription hearing aids (all types) up to 2 every 3 years. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. If a provider is not in our network, you may have to pay upfront and submit a request for reimbursement. See Chapter 2 Payment Requests Contact Information or visit **Humana.com** for information on requesting reimbursement.
DENTAL SERVICES		
Medicare-covered dental	**$0** copay	**$0** or **40%** of the cost
Mandatory supplemental dental benefit Limitations and exclusions may apply. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. Dental benefits under this plan may not cover all ADA procedure codes. Any services received that are not listed will	**DENE81** • Plan covers up to **$3000** allowance every year for non-Medicare covered preventive and comprehensive dental services. • You are responsible for any amount above the dental coverage limit. • Any amount unused at the end of the year will expire.	**DENE81** • Plan covers up to **$3000** allowance every year for non-Medicare covered preventive and comprehensive dental services. • You are responsible for any amount above the dental coverage limit. • Any amount unused at the end of the year will expire.

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
not be covered by the plan and will be the member's responsibility. The member is responsible for any amount above the dental coverage limit. Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. Information regarding each plan is available at **Humana.com/sb**. In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule (but any applicable coinsurance payment still applies). Out-of-network dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Members may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Please see below for provider locator instructions. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for	• Your benefit can be used for most dental treatments such as: • Preventive dental services, such as exams, routine cleanings, etc. • Basic dental services, such as fillings, extractions, etc. • Major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges etc. • Frequency limits may apply. • Note: The allowance cannot be used on fluoride, cosmetic services and implants.	• Your benefit can be used for most dental treatments such as: • Preventive dental services, such as exams, routine cleanings, etc. • Basic dental services, such as fillings, extractions, etc. • Major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges etc. • Frequency limits may apply. • Note: The allowance cannot be used on fluoride, cosmetic services and implants. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

Humana.

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
reimbursement. The coinsurance level will apply to the usual and customary fees in your area. See Chapter 2 Payment Requests Contact Information in your Evidence of Coverage or visit **Humana.com** for information on requesting reimbursement. When visiting an out-of-network provider there could be a difference between Humana's reimbursement and the dentist's charges. Members are responsible for this difference when visiting an out-of-network provider; this is known as balanced billing. Find a dentist in the nationwide Florida GoldPlus Dental network at **Humana.com** > Find Care.		
VISION SERVICES		
Eyewear (post cataract surgery)	**$0** copay	**$0** copay
Medicare-covered diabetic eye exam	**$0** copay	**$0** or **50%** of the cost
Medicare-covered vision services The provider locator for Medicare-covered vision can be found at **Humana.com** > Find Care.	**$0** copay	**$0** or **40%** of the cost
Mandatory supplemental vision benefit The mandatory supplemental vision benefits are provided through the Humana Medicare Insight Network. The provider locator can be found at **Humana.com** > Find Care.	**VIS697** • **$0** copay for routine exam up to 1 per year. • **$40** combined maximum benefit coverage amount per year for routine exam. • **$350** maximum benefit coverage amount per year for	**VIS697** • **$0** copay for routine exam up to 1 per year. • **$40** combined maximum benefit coverage amount per year for routine exam. • **$350** maximum benefit coverage amount per year for

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
	contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • OR • **$400** maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • 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. • Maximum benefit coverage amounts cannot be combined. PLUS providers are part of the Humana Medicare Insight Network and are indicated in the provider locator search results.	contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • 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. • Maximum benefit coverage amounts cannot be combined.
MENTAL HEALTH SERVICES		
Inpatient This plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$0** copay	**$0** or **40%** of the cost
Mental health therapy visits		
• Outpatient hospital	**$0** copay	**$0** or **40%** of the cost
• Partial hospitalization	**$0** copay	**$0** or **40%** of the cost
• Specialist's office	**$0** copay	**$0** or **40%** of the cost
Outpatient substance abuse services		
• Outpatient hospital	**$0** copay	**$0** or **50%** of the cost
• Partial hospitalization	**$0** copay	**$0** or **40%** of the cost
• Specialist's office	**$0** copay	**$0** or **50%** of the cost
• Telehealth	**$0** copay	**Not Covered**

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

Humana.

Medical Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
SKILLED NURSING FACILITY		
This plan covers up to 100 days in a SNF	**$0** copay	**$0** copay per day for days 1-20 **$0** or **$178** copay per day for days 21-100
AMBULANCE		
	$0 copay	**$0** or **20%** of the cost
TRANSPORTATION		
The member *must* contact transportation vendor to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider.	**$0** copay for plan approved location up to 4 one-way trip(s) per year. This benefit offers unlimited miles per trip.	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
MEDICARE PART B DRUGS		
Allergy shots and serum		
• PCP's office	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
Chemotherapy drugs		
• Outpatient hospital	**$0** copay	**$0** or **40%** of the cost
• Specialist's office	**$0** copay	**$0** or **40%** of the cost
Other Part B drugs		
• Outpatient hospital	**$0** copay	**$0** or **20%** of the cost
• PCP's office	**$0** copay	**$0** or **20%** of the cost
• Pharmacy	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** or **20%** of the cost
Part B Insulin		
• Outpatient hospital	**$0** copay	**$0** or **20%** of the cost
• PCP's office	**$0** copay	**$0** or **20%** of the cost
• Pharmacy	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$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 this plan. This is called "preauthorization." To learn more about services that require preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **Humana.com/PAL**.*

Prescription Drug Benefits

PLAN HIGHLIGHTS

"Extra Help"	Most of our members qualify for and are getting "Extra Help" from Medicare to pay for their prescription drug plan costs. If you are in the "Extra Help" program, please refer to the "Extra Help" section below to view your deductible and initial coverage stage cost shares.
100-day supply	Up to 100-day supply on eligible drugs
Insulin costs	You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan.
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

DEDUCTIBLE

This plan has a **$590** deductible. You pay the full cost of your drugs until you reach **$590**. Then, you only pay your cost-share.

INITIAL COVERAGE

You pay the following until your total out-of-pocket costs reach **$2,000**. Once you reach this amount, you will enter the Catastrophic Stage.

Pharmacy Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		**Mail-Order Cost-Sharing**	
Day supply	**30-day**	**100-day***	**30-day**	**100-day***
All Plan-Covered Part D Drugs	25%	25%	25%	25%

To find which pharmacies are available in our network, go to **Humana.com/pharmacyfinder**.
*Some drugs are limited to a 30-day supply and others may be eligible for up to a 100-day supply.

You won't pay more than **$35** for a one-month (up to 30-day) supply of each plan-covered insulin product regardless of cost-sharing tier, even if you haven't paid your deductible.

Humana.

Insulin Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		Mail-Order Cost-Sharing	
Day supply	**30-day**	**100-day***	**30-day**	**100-day***
All Plan-Covered Part D Insulins	$35	$105	$35	$105

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

*Some drugs are limited to a 30-day supply and others may be eligible for up to a 100-day supply.

CATASTROPHIC COVERAGE

After your total out-of-pocket costs reach **$2,000** you pay **$0** for plan-covered Part D drugs.

EXTRA HELP

If you receive "Extra Help" for your drugs you will have a **$0** deductible.

Prior to reaching your annual **$2,000** out-of-pocket limit you will pay one of the following depending on your level of "Extra Help:"

- **$4.90** for generic/preferred multi-source drug or biosimilar; **$12.15** for any other drug; OR
- **$1.60** for generic/preferred multi-source drug or biosimilar; **$4.80** for any other drug; OR
- **$0** for all drugs

After reaching your annual **$2,000** out-of-pocket limit, you will pay **$0** for the remainder of the calendar year, regardless of the level of "Extra Help" you receive. Additional information will be available on your LIS rider.

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 (TTY: 1-800-325-0778), Monday – Friday, 7 a.m. – 7 p.m. For more information on your prescription drug benefit, please call us or access your Evidence of Coverage online.

If you reside at an in-network long-term care facility, you pay the same as you would at an in-network retail pharmacy. Under certain situations you may be able to get drugs from an out-of-network pharmacy but may pay more than you would pay at an in-network pharmacy.

Additional benefits

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
Acupuncture services (Medicare-covered)	**$0** copay for acupuncture for chronic low back pain up to 20 visit(s) per year.	**$0** or **20%** coinsurance for acupuncture for chronic low back pain visits up to 20 visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Chiropractic services (Medicare-covered)	**$0** copay	**$0** or **40%** of the cost
Podiatry services (Medicare-covered)	**$0** copay	**$0** or **40%** of the cost
MEDICAL EQUIPMENT/SUPPLIES		
Continuous glucose monitor (CGM)		
• DME provider	**$0** copay	**$0** copay
• Pharmacy	**$0** copay	**$0** copay
Diabetic monitoring supplies		
• Diabetic supplier	**$0** copay	**$0** or **40%** of the cost
• Network retail pharmacy	**$0** copay	**$0** copay
• Preferred diabetic supplier	**$0** copay	**Not Covered**
Durable medical equipment (DME)	**$0** copay	**$0** or **50%** of the cost
Durable medical equipment (DME) – Oxygen	**$0** copay	**$0** or **50%** of the cost
Medical supplies at medical supplier	**$0** copay	**$0** or **40%** of the cost
Prosthetic devices and related supplies	**$0** copay	**$0** or **40%** of the cost
REHABILITATION SERVICES		
Cardiac rehabilitation services		
• Outpatient hospital	**$0** copay	**$0** or **40%** of the cost
• Specialist's office	**$0** copay	**$0** or **40%** of the cost

Humana.

Additional benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
Occupational therapy		
• Comprehensive outpatient rehab facility	**$0** copay	**$0** or **40%** of the cost
• Outpatient hospital	**$0** copay	**$0** or **40%** of the cost
• Specialist's office	**$0** copay	**$0** or **40%** of the cost
Physical therapy		
• Comprehensive outpatient rehab facility	**$0** copay	**$0** or **40%** of the cost
• Outpatient hospital	**$0** copay	**$0** or **40%** of the cost
• Specialist's office	**$0** copay	**$0** or **40%** of the cost
Pulmonary rehabilitation services		
• Outpatient hospital	**$0** copay	**$0** or **40%** of the cost
• Specialist's office	**$0** copay	**$0** or **40%** of the cost
Speech therapy		
• Comprehensive outpatient rehab facility	**$0** copay .	**$0** or **40%** of the cost
• Outpatient hospital	**$0** copay	**$0** or **40%** of the cost
• Specialist's office	**$0** copay	**$0** or **40%** of the cost
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)		
• Outpatient hospital	**$0** copay	**$0** or **40%** of the cost
• Specialist's office	**$0** copay	**$0** or **40%** of the cost

Medicaid Benefit Comparison

The benefits described in the Covered Medical and Hospital Benefits sections above are covered by HumanaChoice SNP-DE H7284-003 (PPO D-SNP). For each benefit listed below, you can see what Florida Medicaid covers and what this plan covers.

All Medicaid benefits are subject to Florida 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 Florida Medicaid at 1-888-419-3456 (toll free) 1-800-955-8771 (TTY).

BENEFIT	MEDICAID BENEFIT	THIS PLAN BENEFIT
Ambulance	Covered	Covered
Ambulatory surgical center	Covered	Covered

BENEFIT	MEDICAID BENEFIT	THIS PLAN BENEFIT
Dentures	Covered	Covered
Diagnostic services, labs, and imaging	Covered	Covered
Doctor visits	Covered	Covered
Emergency care	Covered	Covered
Eyeglasses	Covered	Covered
Hearing aids	Covered	Covered
Home and community based waiver service programs	Covered	Not Covered
Inpatient hospital	Covered	Covered
Inpatient mental health services, nursing facility and intermediate care facility services in institutions for mental diseases (MD), age 65 and older	Covered	Covered with limitations
Inpatient mental health services, under age 21	Covered	Covered with limitations
Intermediate care facilities for individuals with intellectual disabilities (ICFs-IID)	Covered	Not Covered
Medicare Part B drugs	Covered	Covered
Mental health services	Covered	Covered
Nursing facility services, other than in an institution for mental diseases	Covered	Covered with limitations
Outpatient hospital coverage	Covered	Covered
Physical, occupational, speech therapy	Covered	Covered
Preventive care	Covered	Covered
Skilled nursing facility	Covered	Covered
Transportation	Covered	Covered
Urgently needed services	Covered	Covered

Humana.

More benefits with **this plan**

Enjoy some of these extra benefits included in this plan.
This is a summary of what we cover. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of coverage and services. Visit **Humana.com/PlanDocuments** to view a copy of the EOC or call **1-800-833-2364**.

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.

Routine Acupuncture
$0 copay for acupuncture visits up to 25 visit(s) per year.
Authorization rules may apply.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

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.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

Humana Well Dine® Meal Program
$0 copayment for Humana Well Dine® meal program.

After your inpatient stay in either a hospital or a nursing facility, you may be eligible to receive 2 home delivered meals per day for 7 days (up to 14 meals).

Meals must be requested within 30 days of discharge from your inpatient stay.

Limited to 4 times per year.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

Rewards and Incentives - Go365® by Humana
Complete eligible healthy activities, like preventive screenings and exams, and get rewarded.

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

SilverSneakers® fitness program
Live a healthier, more active life through fitness and social connection at participating locations and online.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

Notice of Non-Discrimination

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Humana Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a 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, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019, 800-537-7697 (TDD)**.

This notice is available at **www.humana.com/legal/non-discrimination-disclosure**.

GHHNDN2025HUM

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（听障专线：711）。我们的中文工作人员很乐意帮助您。这是一项免费服务。

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

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (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 .

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

Humana.

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 بخطتنا الصحية أو خطة الأدوية الموصوفة 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.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (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：当社の健康保険と処方薬プランに関するご質問にお答えするために、無料の通訳サービスをご用意しています。通訳をご用命になるには、1-877-320-1235 (TTY：711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。

Find out **more**

Need help finding a doctor or pharmacy? You can see this plan's **Provider and Pharmacy Directory** at our website at **Humana.com/Find-Care** or call us at the number listed at the beginning of this booklet and we will send you one. Many doctor listings include a Care Highlight® rating. These ratings in clinical quality and cost-efficiency can help you make informed choices about your healthcare. Ratings only appear when we have enough information to measure a doctor's clinical quality and cost-efficiency. Learn more at **Humana.com/CareHighlight**.

You can see this 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.

Clinical quality and cost-efficiency ratings are available in all states except Alaska. Ratings are not available for all physicians. Care Highlight is intended for informational purposes only. Members have access to all physicians in the Humana network, regardless of whether or not the physician has a Care Highlight rating. Ratings should not be the sole basis for selecting a doctor. Humana does not give performance-based payments to doctors based on these ratings. Ratings do not guarantee the quality or outcome of healthcare services.

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.

HumanaChoice SNP-DE H7284-003 (PPO D-SNP) 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 HumanaChoice SNP-DE H7284-003 (PPO D-SNP) Model of Care.

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

If you get Medicare cost-share assistance, HumanaChoice SNP-DE H7284-003 (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 billed or asked to pay an in-network 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.

Humana.

Find out **more** *(Continued)*

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 this 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.

More information is just a click away.

Visit **Humana.com/PlanDocuments** to see additional details about this plan, including benefits and costs.

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

Activate your secure MyHumana account.

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

Already have an account?

Go to **Humana.com/Member/ManageYourAccount** and log in.

Don't have an account yet?

Create one using the same link above in just minutes.

Receiving information about other insurance products

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

Humana.

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

Important information about this plan

Humana.com

H7284_SB_MAPD_PPO_003000_2025_M