2019

Summary of Benefits

HumanaChoice® R5826-018 (Regional PPO)

Region 9
State of Florida

Our service area includes the following state(s): Florida.

Humana®

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

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. 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.

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, 2020.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, 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.

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Let's talk about HumanaChoice R5826-018 (Regional PPO)

Find out more about the HumanaChoice R5826-018 (Regional PPO) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice R5826-018 (Regional PPO) is a Medicare Advantage PPO plan with a Medicare contract. 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" or you will receive one after you enroll.

To be eligible

To join HumanaChoice R5826-018 (Regional PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

HumanaChoice R5826-018 (Regional PPO)

How to reach us:

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.

More about HumanaChoice R5826-018 (Regional PPO)

Do you have Medicare and Medicaid? If you are a dual-eligible beneficiary enrolled in both Medicare and the state's program, you may not have to pay the medical costs displayed in this booklet and your prescription drug costs will be lower, too.

If you have Medicaid, be sure to show your Medicaid ID card in addition to your Humana membership card to make your provider aware that you may have additional coverage. Your services are paid first by Humana and then by Medicaid.

As a member it's a good idea to select a doctor as your Primary Care Provider (PCP). HumanaChoice R5826-018 (Regional PPO) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, you may be subject to higher copayments/coinsurance.

A healthy partnership

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

Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
PLAN COSTS		
Monthly plan premium You must keep paying your Medicare Part B premium.	**$0**	
Medical deductible		**$975** combined in- and out-of-network All services received from in network providers are excluded from the combined deductible. Services not covered by Original Medicare, Ambulance services, Emergency room services, Urgently Needed Services at Urgent Care Centers, Immunizations (Flu & Pneumonia) received from out-of-network providers are also excluded from the combined deductible.
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for medical services for the year.	**$6,700** in-network **$10,000** combined in- and out-of-network	**$10,000** combined in- and out-of-network

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
	$195 copay per day for days 1-10 **$0** copay per day for days 11-90 Your plan covers an unlimited number of days for an inpatient stay.	**$245** copay per day for days 1-10 **$0** copay per day for days 11-90
OUTPATIENT HOSPITAL COVERAGE		
Outpatient surgery at outpatient hospital	**$100** copay	**30%** of the cost
Outpatient surgery at ambulatory surgical center	**$75** copay	**30%** of the cost

You do not need a referral to receive covered services from 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.)

	IN-NETWORK	OUT-OF-NETWORK
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$10** copay	**$45** copay
Specialists	**$45** copay	**$45** copay
PREVENTIVE CARE		
	Our plan covers many preventive services at no cost when you see an in-network provider including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including flu shots, hepatitis B shots, pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Annual Wellness Visit • Lung cancer screening • Routine physical exam	**$0** to **$45** copay or **30%** of the cost, depending on the service and where service is provided

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
	• 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.	**$90** copay	**$90** copay
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$25** copay at an urgent care center	**30%** of the cost at an urgent care center
OUTPATIENT CARE AND DIAGNOSTIC SERVICES, LABS AND IMAGING Cost share may vary depending on the service and where service is provided		
Diagnostic Mammography	**$45** to **$90** copay	**$45** or **30%** of the cost
Diagnostic radiology	**$75** to **$125** copay	**$75** or **30%** of the cost
Lab services	**$0** to **$100** copay	**$45** or **30%** of the cost
Diagnostic tests and procedures	**$0** to **$100** copay	**$45** or **30%** of the cost
Outpatient X-rays	**$10** to **$100** copay	**$45** or **30%** of the cost
Radiation Therapy	**$45** or **20%** of the cost	**$45** or **30%** of the cost
HEARING SERVICES		
Medicare covered hearing	**$45** copay	**$45** copay

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Routine hearing HER833	• **$0** copayment for fitting/evaluation, routine hearing exam up to 1 per year. • **$1000** combined maximum benefit coverage amount for hearing aids (all types) up to 1 every 3 years.	• **25%** coinsurance for hearing aids (all types) up to 1 every 3 years. • **25%** coinsurance for fitting/evaluation, routine hearing exams up to 1 per year. • **$1000** combined maximum benefit coverage amount for hearing aids (all types) up to 1 every 3 years. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
DENTAL SERVICES The cost-share indicated below is what you pay for the covered service.		
Medicare covered dental	**$45** copay	**$45** copay
Routine dental DEN762 Use the CAREington Medicare 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 network drop down select CAREington Medicare.	• **0%** coinsurance for bitewing x-rays up to 1 set(s) per year. • **0%** coinsurance for amalgam filling, denture reline, extractions up to 1 per year. • **0%** coinsurance for composite filling, periodic oral exam and/or comprehensive oral evaluation, prophylaxis (cleaning) up to 2 per year. • **0%** coinsurance for necessary anesthesia with covered service up to unlimited per year.	• **50%** coinsurance for bitewing x-rays up to 1 set(s) per year. • **50%** coinsurance for amalgam filling, denture reline, extractions up to 1 per year. • **50%** coinsurance for composite filling, periodic oral exam and/or comprehensive oral evaluation, prophylaxis (cleaning) up to 2 per year. • **50%** coinsurance for necessary anesthesia with covered service up to unlimited per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
VISION SERVICES		
Medicare covered vision services	**$45** copay	**$45** copay
Diabetic Eye Exam	**$0** copay	**$45** copay
Glaucoma screening	**$0** copay	**$45** copay
Eyewear (post-cataract)	**$0** copay	**$0** copay

You do not need a referral to receive covered services from 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.)

	IN-NETWORK	OUT-OF-NETWORK
Routine vision VIS776 The provider locator can be found at Humana.com > Find a Doctor > from the Search Type drop down select Vision > Eyemed Select Network.	• **$130** maximum benefit coverage amount per year for routine exam, refraction up to 1 per year.	• **$130** maximum benefit coverage amount per year for routine exam, refraction up to 1 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	**$160** copay per day for days 1-10 **$0** copay per day for days 11-90	**$245** copay per day for days 1-10 **$0** copay per day for days 11-90
Outpatient group and individual therapy visits Cost share may vary depending on where service is provided.	**$40** to **$100** copay	**$45** or **30%** 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 **$150** copay per day for days 21-100	**$250** copay per day for days 1-58 **$0** copay per day for days 59-100
PHYSICAL THERAPY		
Cost share may vary depending on the service and where service is provided.	**$25** to **$40** copay	**$45** or **30%** of the cost
AMBULANCE		
Ambulance (ground)	**$265** per date of service	**$265** per date of service
TRANSPORTATION		
	Not covered	Not covered

Prescription Drug Benefits

MEDICARE PART B DRUGS		
Chemotherapy drugs	**20%** of the cost	**30%** of the cost
Other part B drugs	**20%** of the cost	**20%** of the cost

You do not need a referral to receive covered services from 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.

PRESCRIPTION DRUGS

Your plan covers Part B drugs including, but not limited to, chemotherapy and some drugs administered by your provider. However, this plan does not cover Part D prescription drugs.

Additional benefits

	IN-NETWORK	OUT-OF-NETWORK
Medicare-covered foot care (podiatry)	**$45** copay	**$45** copay
Medicare-covered chiropractic services	**$20** copay	**$45** copay
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**20%** of the cost	**20%** of the cost
Medical Supplies	**18%** of the cost	**20%** of the cost
Prosthetics (artificial limbs or braces)	**20%** of the cost	**20%** of the cost
Diabetic monitoring supplies Cost share may vary depending on where service is provided.	**$0** or **20%** of the cost	**30%** of the cost
REHABILITATION SERVICES		
Physical, occupational and speech therapy Cost share may vary depending on the service and where service is provided.	**$25** to **$40** copay	**$45** or **30%** of the cost
Cardiac rehabilitation Cost share may vary depending on the service and where service is provided.	**$40** copay	**$45** or **30%** of the cost
Pulmonary rehabilitation Cost share may vary depending on the service and where service is provided.	**$30** copay	**$45** or **30%** of the cost

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

Travel Coverage
As a member of a HumanaChoice (PPO), you have the benefit to use Humana's network of providers across the U.S. (not available in all counties). If you are visiting another HumanaChoice (PPO) service area, simply access a Humana network provider to receive your in-network level of benefits for up to twelve consecutive months. You pay your in-network copay or coinsurance when you visit a participating provider for non-emergency care, including preventive care, specialist care and hospitalizations. Visit **Humana.com** or contact Customer Care on the back of your ID card if you need help finding an in-network provider.

Well Dine Meal Program
Humana's meal program for members following an inpatient stay in the hospital or nursing facility

HumanaFirst® Nurse Hotline
Health advice from a registered nurse, available 24 hours a day, seven days a week.

Over-the-Counter (OTC) mail order
Up to **$10** allowance every 3 months for the purchase of OTC supplies from Humana Pharmacy mail delivery.

Virtual Visits - Medical
Access to doctors and other practitioners via phone and/or video technology for diagnosis and treatment of certain non-emergency medical issues.

You pay a **$10** copay to receive a remote medical consultation.

Virtual Visits – Mental and Behavioral Health
Access to doctors and other mental health professionals via phone and/or video technology for diagnosis and treatment of certain non-emergency mental or behavioral issues.

You pay a **$20** copay to receive a remote mental and behavioral consultation.

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

Go365™ by Humana
Rewards for completing certain preventive health screenings and health and wellness activities.

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

Find out **more**

You can see our plan's **provider 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.

This information is not a complete description of benefits. Call 1-800-457-4708 (TTY: 711) for more information.

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.

This information is available in a different format, including Braille, large print, and audio tapes. Please call Customer Care at the number listed in the beginning of this document if you need plan information in another format.
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-833-2364 (TTY: 711).

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

Limitations on healthcare and prescription services delivered via virtual visits and communications options vary by state. Virtual visit services are not a substitute for emergency care and not intended to replace your primary care provider or other providers in your network. This material is provided for informational use only and should not be construed as medical advice or used in place of consulting a licensed medical professional.

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.

Humana®

Humana.com

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion.

Humana Inc. and its subsidiaries provide: (1) 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; and, (2) free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call **1-877-320-1235** or if you use a **TTY**, call **711**.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion, you can file a grievance with 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 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, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Multi-Language Interpreter Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-877-320-1235 **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-1235 **(TTY: 711)** 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 1-877-320-1235 **(TTY : 711)**。 ... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-320-1235 **(TTY: 711)**.... 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-877-320-1235 **(TTY: 711)** 번으로 전화해 주십시오 .... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-320-1235 **(TTY: 711)**.... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-320-1235 **(телетайп: 711)**.... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-320-1235 **(TTY: 711)**.... ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-320-1235 **(ATS: 711)**.... UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-320-1235 **(TTY: 711)**.... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-320-1235 **(TTY: 711)**.... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-320-1235 **(TTY: 711)**.... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-320-1235 **(TTY: 711)**.... 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。 1-877-320-1235 **(TTY: 711)** まで、お電話にてご連絡ください。...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-320-1235 تماس بگیرید. **(TTY: 711)**

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-877-320-1235 **(TTY: 711)**....

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-320-1235 **(رقم هاتف الصم والبكم: 711)**.

HumanaChoice R5826-018 (Regional PPO)
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State of Florida

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