

# Summary of Benefits

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## **Humana Honor (HMO) H1036-056**

Daytona  
Flagler and Volusia counties

Our service area includes the following county/counties in Florida: Flagler, Volusia.

**Humana<sup>®</sup>**

## 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

- ☐ You do not pay a separate monthly plan premium for this Humana plan but, 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, 2023.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

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# Let's talk about Humana Honor (HMO)

Find out more about the Humana Honor (HMO) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Honor (HMO) is a Medicare Advantage HMO 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".

## To be eligible

To join Humana Honor (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

## Plan name:

Humana Honor (HMO)

## 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](https://www.humana.com/medicare)**

## More about Humana Honor (HMO)

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.

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 you must select an in-network doctor to act as your Primary Care Provider (PCP). Humana Honor (HMO) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services.



## A healthy partnership

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



## Monthly Premium, Deductible and Limits

<b>Monthly Plan Premium</b>	<b>\$0</b> You must keep paying your Medicare Part B premium.
<b>Part B premium reduction</b>	Your plan will reduce your Monthly Part B premium by up to <b>\$80</b>
<b>Medical deductible</b>	This plan does not have a deductible.
<b>Maximum out-of-pocket responsibility</b>	<b>\$5,500</b> in-network The most you pay for copays, coinsurance and other costs for medical services for the year.



## Covered Medical and Hospital Benefits

<b>Acute inpatient hospital care</b>	<b>\$175</b> copay per day for days 1-7 <b>\$0</b> copay per day for days 8-90 Your plan covers an unlimited number of days for an inpatient stay.
<b>Outpatient hospital coverage</b>	<ul style="list-style-type: none"> <li>• Outpatient surgery at Outpatient Hospital: <b>\$175</b> copay</li> <li>• Outpatient surgery at Ambulatory Surgical Center: <b>\$50</b> copay</li> </ul>
<b>Doctor visits</b>	<ul style="list-style-type: none"> <li>• Primary care provider: <b>\$0</b> copay</li> <li>• Specialist: <b>\$20</b> copay</li> </ul>

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." 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 referral and/or prior authorization from the plan.



## Covered Medical and Hospital Benefits (cont.)

### 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
- Medicare diabetes prevention program

Any additional preventive services approved by Medicare during the contract year will be covered.

### EMERGENCY CARE

#### Emergency room

**\$90** copay

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.

#### Urgently needed services

**\$15** copay at an urgent care center

Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.

### OUTPATIENT CARE AND SERVICES

#### Diagnostic services, labs and imaging

Cost share may vary depending on the service and where service is provided

- Diagnostic mammography: **\$20** to **\$25** copay
- Diagnostic radiology: **\$50** copay
- Lab services: **\$0** to **\$15** copay
- Diagnostic tests and procedures: **\$0** to **\$50** copay
- Outpatient X-rays: **\$0** to **\$25** copay
- Radiation therapy: **\$20** to **\$25** copay

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## Covered Medical and Hospital Benefits (cont.)

### Hearing

Medicare-covered hearing exam: **\$20** copay

#### Routine hearing:

In-Network:

#### HER691

- **\$0** copayment for fitting/evaluation, routine hearing exams up to 1 per year.
- **\$399** copayment for each Value Technology hearing aid up to 1 per ear per year.
- **\$899** copayment for each Advanced Technology hearing aid up to 1 per ear per year.
- **\$1299** copayment for each Premium Technology hearing aid up to 1 per ear per year.
- Note: Includes 1 year warranty and 1 month battery supply.

### Dental

Medicare-covered dental services: **\$20** copay

#### Routine dental:

The cost-share indicated below is what you pay for the covered service.

In-Network:

#### DEN613

- **0%** coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.
- **0%** coinsurance for comprehensive oral evaluation or periodontal exam, scaling for moderate inflammation up to 1 every 3 years.
- **0%** coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years.
- **0%** coinsurance for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.
- **0%** coinsurance for emergency diagnostic exam up to 1 per year.
- **0%** coinsurance for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year.
- **0%** coinsurance for periodontal maintenance up to 4 per year.
- **0%** coinsurance for amalgam and/or composite filling, necessary anesthesia with covered service up to unlimited per year.
- **\$1000** maximum benefit coverage amount per year for preventive and comprehensive benefits.

Dental benefits may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**.

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.

### Vision

- Medicare-covered vision services: **\$20** copay

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." 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 referral and/or prior authorization from the plan.



## Covered Medical and Hospital Benefits (cont.)

- Medicare-covered diabetic eye exam: **\$0** copay
- Medicare-covered glaucoma screening: **\$0** copay
- Medicare-covered eyewear (post-cataract): **\$0** copay

### Routine vision:

In-Network:

#### **VIS091**

- **\$0** copayment for routine exam up to 1 per year.
- **\$150** maximum benefit coverage amount per year for contact lenses, eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames or 1 pair of select eyeglasses at no cost.
- Eyeglasses include ultraviolet protection and scratch resistant coating.

Refraction is only covered when billed as part of the routine vision exam.

Search for Vision providers in the Medical network of this Medicare Advantage plan.

### **Mental health services**

#### **Inpatient:**

- **\$175** copay per day for days 1-7
- **\$0** copay per day for days 8-90
- Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.

**Outpatient** (group and individual therapy visits): **\$5** to **\$50** copay  
Cost share may vary depending on where service is provided.

### **Skilled nursing facility (SNF)**

- **\$0** copay per day for days 1-20
- **\$150** copay per day for days 21-100
- Your plan covers up to 100 days in a SNF

### **Physical Therapy**

Cost share may vary depending on the service and where service is provided.

- **\$10** to **\$40** copay

## **ADDITIONAL BENEFITS**

### **Ambulance (ground)**

**\$240** copay per date of service

### **Ambulance (air)**

**20%** of the cost

### **Transportation**

**\$0** copay for plan approved location up to 50 one-way trip(s) per year.

The member *must* contact transportation vendor to arrange transportation.

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." 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 referral and/or prior authorization from the plan.



## Prescription Drug Benefits

### Medicare Part B drugs

- Chemotherapy drugs: **20%** of the cost
- Other Part B drugs: **20%** of the cost

### 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

### Medicare-covered foot care (podiatry)

**\$20** copay

### Medicare-covered chiropractic services

**\$20** copay

### Medical equipment/ supplies

Cost share may vary depending on the service and where service is provided

- Durable medical equipment (like wheelchairs or oxygen): **\$0** copay or **20%** of the cost
- Medical supplies: **\$0** copay
- Prosthetics (artificial limbs or braces): **20%** of the cost
- Diabetic monitoring supplies: **\$0** copay or **20%** of the cost

### Rehabilitation services

Cost share may vary depending on the service and where service is provided.

- Occupational and speech therapy: **\$10** to **\$40** copay
- Cardiac rehabilitation: **\$20** copay
- Pulmonary rehabilitation: **\$15** to **\$20** copay

### Telehealth services (in addition to Original Medicare)

- Primary care provider (PCP): **\$0** copay
- Specialist: **\$20** copay
- Urgent care services: **\$0** copay
- Substance abuse and behavioral health services: **\$0** copay



# More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

## **COVID-19 Testing and Treatment**

**\$0** copay for testing and treatment services for COVID-19.

## **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 attempt 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**

**\$20** copay per visit for unlimited visits.

## **Deliver Fresh Meal Program**

Humana's meal program for members following an inpatient stay in the hospital or nursing facility.

## **Over-the-Counter (OTC) mail order**

**\$100** maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products.

## **Rewards and Incentives**

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

## **SilverSneakers® fitness program**

Basic fitness center membership including fitness classes.



Find out **more**

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You can see our plan's **provider directory** at our website at **[humana.com/finder/search](http://humana.com/finder/search)** 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.

Medicare-covered eye refractions during a specialist medical visit are not covered.

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.

**Humana**®

**Humana.com**

# 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, marital status or religion. 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.

### Language assistance services, free of charge, are available to you.

**1-877-320-1235 (TTY: 711)**

**Español (Spanish):** Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

**繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。

**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

**Русский (Russian):** Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

**Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

**Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.

**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

**日本語 (Japanese):** 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

**فارسی (Farsi)**

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

**Diné Bizaad (Navajo):** Wóda'í béésh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'déé nika'adoowoł.

**العربية (Arabic)**

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك





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H1036056000 ENG

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**Humana.com**

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