2022

# Summary of Benefits

## Humana Gold Plus SNP-DE H1036-245 (HMO D-SNP)

Panhandle
Certain Panhandle Counties

Our service area includes the following county/counties in Florida: Bay, Escambia, Okaloosa, Santa Rosa, Walton.

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.
- ☐ 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.

### 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, 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).
- ☐ 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 dual eligibles who are QMB, SLMB, QI or QDWI.

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Our service area includes the following county/counties in Florida: Bay, Escambia, Okaloosa, Santa Rosa, Walton.

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# Let's talk about Humana Gold Plus SNP-DE H1036-245 (HMO D-SNP)

Find out more about the Humana Gold Plus SNP-DE H1036-245 (HMO D-SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus SNP-DE H1036-245 (HMO D-SNP) is a Coordinated Care plan with a Medicare contract and a contract with the Florida Medicaid. 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 you must select an in-network doctor to act as your Primary Care Provider (PCP). Humana Gold Plus SNP-DE H1036-245 (HMO D-SNP) 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. 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 Humana Gold Plus SNP-DE H1036-245 (HMO 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 a dual eligible.

Humana Gold Plus SNP-DE H1036-245 (HMO D-SNP) may enroll dual eligibles who are QMB, SLMB, QI or QDWI.

## Plan name:

Humana Gold Plus SNP-DE H1036-245 (HMO D-SNP)

## More about Humana Gold Plus SNP-DE H1036-245 (HMO 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 Comprehensive Benefit Chart shows the benefits you will receive from Humana and how Medicaid covers your cost sharing for those plan benefits if you are in a cost share protected category. The chart also lists some benefits you could receive from Medicaid if you are eligible for full Medicaid benefits. If you are entitled to Medicaid benefits your care coordinator will work with you to assist you in understanding and accessing the Medicare and Medicaid benefits you may be entitled to. Be sure to show the Florida 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.

## 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**.

For the most current Florida Medicaid coverage information, please visit the Florida Medicaid website at **http://ahca.myflorida.com/** 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!

## Monthly Premium, Deductible and Limits

| | |
|---|---|
| **Monthly plan premium** | **$0** or up to **$21.80** depending on your level of assistance<br>You must keep paying your Medicare Part B premium. The Part B premium may be covered through 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** | **$6,700** in-network<br>The most you pay for copays, coinsurance and other costs for medical services for the year. |

## Covered Medical and Hospital Benefits

**The benefit chart below shows the benefits you will receive as a member of Humana Gold Plus SNP-DE H1036-245 (HMO D-SNP) (left column) compared to what is currently provided by Traditional Florida Medicaid (right column). If you are currently enrolled in a Medicaid Managed Care Plan, the benefits may be different from what's listed in the right column. For each benefit listed below, you can see what you pay as a member of our plan compared to Traditional Florida Medicaid's coverage and charges. NOTE: You cannot be enrolled in both a Medicaid Managed Care plan and a D-SNP plan in Florida. For members protected by the Florida Medicaid Program from cost sharing, Medicaid pays coinsurance, copays and deductibles for Original Medicare-covered services.**

| | **WHAT YOU PAY ON THIS HUMANA PLAN** | **COMPARED TO TRADITIONAL FLORIDA MEDICAID BENEFITS (MEDICAID MANAGED CARE PLAN BENEFITS MAY BE DIFFERENT)** |
|---|---|---|
| **ACUTE INPATIENT HOSPITAL CARE** | | |
| | **$0** or **$150** copay per day for days 1-5<br>**$0** copay per day for days 6-90<br>If you are cost-share protected by the State (QMB) you pay nothing | **$0** copay for each admission** |
| **OUTPATIENT HOSPITAL COVERAGE** | | |
| **Outpatient surgery at outpatient hospital** | **$0** or<br>**$75** copay<br>If you are cost-share protected by the State (QMB) you pay nothing | **$3** copay per day for outpatient services provided in an outpatient setting other than the emergency department** |
| **Outpatient surgery at ambulatory surgical center** | **$0** or **$25** copay<br>If you are cost-share protected by the State (QMB) you pay nothing | **$0** copay per day for outpatient services provided in an outpatient setting other than the emergency department** |

*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.)

| | WHAT YOU PAY ON THIS HUMANA PLAN | COMPARED TO TRADITIONAL FLORIDA MEDICAID BENEFITS (MEDICAID MANAGED CARE PLAN BENEFITS MAY BE DIFFERENT) |
|---|---|---|
| **DOCTOR OFFICE VISITS** | | |
| **Primary care provider (PCP)** | **$0** copay | • Provider services include physicians, nurse practitioners and physician assistants<br>– **$2** copay per provider/group, per day** |
| **Specialists** | **$0** copay | • Services provided in federally qualified health centers (FQHC's), clinics, and rural health centers<br>– **$3** copay per clinic, per day** |
| **PREVENTIVE CARE** | | |
| | **Our plan covers many preventive services at no cost when you see an in-network provider including:**<br>• Abdominal aortic aneurysm screening<br>• Alcohol misuse counseling<br>• Bone mass measurement<br>• Breast cancer screening (mammogram)<br>• Cardiovascular disease (behavioral therapy)<br>• Cardiovascular screenings<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)<br>• Depression screening<br>• Diabetes screenings<br>• HIV screening<br>• Medical nutrition therapy services<br>• Obesity screening and counseling<br>• Prostate cancer screenings (PSA) | |

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| | WHAT YOU PAY ON THIS HUMANA PLAN | COMPARED TO TRADITIONAL FLORIDA MEDICAID BENEFITS (MEDICAID MANAGED CARE PLAN BENEFITS MAY BE DIFFERENT) |
|---|---|---|
| | • Sexually transmitted infections screening and counseling<br>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>• Vaccines, including flu shots, hepatitis B shots, pneumococcal shots<br>• "Welcome to Medicare" preventive visit (one-time)<br>• Annual Wellness Visit<br>• Lung cancer screening<br>• Routine physical exam<br>• Medicare diabetes prevention program<br>Any additional preventive services approved by Medicare during the contract year will be covered. | |
| **EMERGENCY CARE** | | |
| **Emergency room**<br>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<br>If you are cost-share protected by the State (QMB) you pay nothing | Medicaid recipients using the hospital emergency room for non-emergency services are responsible for a **5%** coinsurance on the first **$300** of the Florida Medicaid payment (maximum **$15** per day)** |
| **Urgently needed services**<br>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. | **$0** copay at an urgent care center | **$3.00** copay per day** |

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# Covered Medical and Hospital Benefits (cont.)

| | WHAT YOU PAY ON THIS HUMANA PLAN | COMPARED TO TRADITIONAL FLORIDA MEDICAID BENEFITS (MEDICAID MANAGED CARE PLAN BENEFITS MAY BE DIFFERENT) |
|---|---|---|
| **DIAGNOSTIC SERVICES, LABS AND IMAGING** | | |
| **Diagnostic mammography** | **$0** to **$75** copay<br>If you are cost-share protected by the State (QMB) you pay nothing | **$3.00** copay one per recipient per year** |
| **Diagnostic radiology** | **$0** to **$75** copay<br>If you are cost-share protected by the State (QMB) you pay nothing | • **$1.00** copay per portable X-ray service, per day<br>• **$2.00** copay per practitioner office visit, per day<br>• **$3.00** copay per Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) or visit, per day<br>• **$3.00** copay for outpatient place of service |
| **Lab services** | **$0** to **$50** copay<br>If you are cost-share protected by the State (QMB) you pay nothing | • **$1.00** copay per independent laboratory visit, per day<br>• **$2.00** copay per practitioner office visit, per day<br>• **$3.00** copay per Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) or visit, per day<br>• **$3.00** copay for outpatient place of service |
| **Diagnostic tests and procedures** | **$0** to **$75** copay<br>If you are cost-share protected by the State (QMB) you pay nothing | • **$1.00** copay per independent laboratory visit, per day<br>• **$2.00** copay per practitioner office visit, per day<br>• **$3.00** copay per Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) or visit, per day<br>• **$3.00** copay for outpatient place of service |

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## Covered Medical and Hospital Benefits (cont.)

| | WHAT YOU PAY ON THIS HUMANA PLAN | COMPARED TO TRADITIONAL FLORIDA MEDICAID BENEFITS (MEDICAID MANAGED CARE PLAN BENEFITS MAY BE DIFFERENT) |
|---|---|---|
| **Outpatient X-rays** | **$0** to **$75** copay<br>If you are cost-share protected by the State (QMB) you pay nothing | **$3.00** copay per day |
| **Radiation therapy** | **$0** to **$60** copay<br>If you are cost-share protected by the State (QMB) you pay nothing | • **$1.00** copay per portable X-ray service, per day<br>• **$2.00** copay per practitioner office visit, per day<br>• **$3.00** copay per federally qualified health center visit, per day<br>• **$3.00** copay per rural health clinic visit, per day<br>• **$3.00** copay for outpatient place of service |
| **HEARING SERVICES** | | |
| **Medicare-covered hearing** | **$0** copay | • **$0** copay<br>• Replacement of hearing Devices<br>• Hearing Assessment and Reassessment<br>• Cochlear Implants<br>• Diagnostic Audiological Tests when medically necessary by a physician's examination or to document treatment outcome |
| **Routine hearing** | In-network:<br>**HER751**<br>• **$0** copayment for fitting/evaluation, routine hearing exams up to 1 per year.<br>• **$500** maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year.<br>• Note: Includes 1 month battery supply and 2 year warranty. | |

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# Covered Medical and Hospital Benefits (cont.)

| | WHAT YOU PAY ON THIS HUMANA PLAN | COMPARED TO TRADITIONAL FLORIDA MEDICAID BENEFITS (MEDICAID MANAGED CARE PLAN BENEFITS MAY BE DIFFERENT) |
|---|---|---|
| **DENTAL SERVICES**<br>The cost-share indicated below is what you pay for the covered service. | | |
| **Medicare-covered dental** | **$0** copay | • **$0** copay<br>• Limited adult dental services for recipients ages 21 and over<br>• **$3** copay if the dental service is provided in a Federally Qualified Health Centers (FQHC) |
| **Routine dental**<br><br>Dental benefits may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**.<br><br>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. | In-network:<br>**DEN647**<br>• **0%** coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.<br>• **0%** coinsurance for comprehensive oral evaluation or periodontal exam, scaling for moderate inflammation up to 1 every 3 years.<br>• **0%** coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years.<br>• **0%** coinsurance for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.<br>• **0%** coinsurance for emergency diagnostic exam up to 1 per year.<br>• **0%** coinsurance for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year.<br>• **0%** coinsurance for periodontal maintenance up to 4 per year.<br>• **0%** coinsurance for amalgam and/or composite filling, necessary anesthesia with covered service up to unlimited per year.<br>• **$4000** maximum benefit coverage amount per year for preventive and comprehensive benefits. | |

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|---|---|---|
| **DENTAL SERVICES (continued)** | | |
| | Depending on your level of Medicaid eligibility, additional benefits may be provided by the plan:<br>• **$0** copay for acute emergency dental procedures to alleviate pain or infection, including incision and drainage of an abscess and necessary radiographs to make a diagnosis<br>• **$0** copay for necessary extractions and surgical procedures to fit the mouth for dentures | |
| **VISION SERVICES** | | |
| **Medicare-covered vision services** | **$0** copay | • Recipients are responsible for the following copayment, unless the recipient is exempt from copayment requirements or the copayment is waived by the Florida Medicaid managed care plan in which the recipient is enrolled<br>• **$2.00** per practitioner office visit, per day<br>• **$3.00** per federally qualified health center visit, per day<br>• **$3.00** per rural health clinic visit, per day<br>• One initial consultation visit per year<br>• Pathology and laboratory services<br>• Special ophthalmological services when performed in addition to a general ophthalmological, or evaluation and management visit |

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|---|---|---|
| | | • Up to two evaluation and management visits per month<br>• Up to two refractions every 365 days<br>• Visual examination services performed when there is a reported vision problem, illness, disease, or injury |
| **Medicare-covered diabetic eye exam** | **$0** copay | |
| **Medicare-covered glaucoma screening** | **$0** copay | |
| **Medicare-covered eyewear (post-cataract)** | **$0** copay | |
| **Routine vision**<br><br>Refraction is only covered when billed as part of the routine vision exam.<br><br>Search for Vision providers in the Medical network of this Medicare Advantage plan. | In-network:<br>**VIS093**<br>• **$0** copayment for routine exam up to 1 per year.<br>• **$180** maximum benefit coverage amount per year for contact lenses, eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.<br>• Eyeglasses include ultraviolet protection and scratch resistant coating. | |

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# Covered Medical and Hospital Benefits (cont.)

| | WHAT YOU PAY ON THIS HUMANA PLAN | COMPARED TO TRADITIONAL FLORIDA MEDICAID BENEFITS (MEDICAID MANAGED CARE PLAN BENEFITS MAY BE DIFFERENT) |
|---|---|---|
| **MENTAL HEALTH SERVICES** | | |
| **Inpatient**<br>Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital | **$0** or **$150** copay per day for days 1-5<br>**$0** copay per day for days 6-90<br>If you are cost-share protected by the State (QMB) you pay nothing | **$0** copay per admission<br>The plan shall cover up to 45 days of inpatient hospital coverage and up to 365 days of emergency inpatient care, including behavioral health |
| **Outpatient group and individual therapy visits** | **$0** to **$75** copay<br>If you are cost-share protected by the State (QMB) you pay nothing | • **$2** copay per outpatient hospital visit<br>• **Group Therapy**<br>– Services for a group of people to have therapy sessions with a mental health professional.<br>• **Individual Therapy Services**<br>– Services for individuals to have therapy sessions with a mental health professional.<br>• **Family Therapy**<br>– Services for families to have therapy sessions with a mental health professional. |
| **SKILLED NURSING FACILITY (SNF)** | | |
| Your plan covers up to 100 days in a SNF | **$0** copay per day for days 1-20<br>**$0** or **$155** copay per day for days 21-100<br>If you are cost-share protected by the State (QMB) you pay nothing | • **$0** copay |

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| | WHAT YOU PAY ON THIS HUMANA PLAN | COMPARED TO TRADITIONAL FLORIDA MEDICAID BENEFITS (MEDICAID MANAGED CARE PLAN BENEFITS MAY BE DIFFERENT) |
|---|---|---|
| **PHYSICAL THERAPY** | | |
| | **$0** to **$40** copay | • **$0** copay<br>• Physical therapy services for recipients under the age of 21 years:<br>• One initial therapy evaluation per year, per recipient<br>• One therapy re-evaluation every five months, per recipient<br>• Wheel chair evaluation all ages:<br>– One initial wheelchair evaluation every five years per recipient<br>– One follow-up wheelchair evaluation including adjustments and fittings when the wheelchair is delivered<br>– One follow-up wheelchair evaluation including adjustments and fittings six months after the wheelchair has been delivered |
| **AMBULANCE** | | |
| **Ambulance (ground)** | **$0** or **$200** copay per date of service<br>If you are cost-share protected by the State (QMB) you pay nothing | **$0** copay |
| **Ambulance (air)** | **$0** or **20%** of the cost<br>If you are cost-share protected by the State (QMB) you pay nothing | **$0** copay |
| **TRANSPORTATION** | | |
| | **$0** copay for plan approved location up to 24 one-way trip(s) per year.<br><br>The member *must* contact transportation vendor to arrange transportation. | **$0** copay for emergency transportation |

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# Prescription Drug Benefits

| | WHAT YOU PAY ON THIS HUMANA PLAN | COMPARED TO TRADITIONAL FLORIDA MEDICAID BENEFITS (MEDICAID MANAGED CARE PLAN BENEFITS MAY BE DIFFERENT) |
|---|---|---|
| **MEDICARE PART B DRUGS** | | |
| **Chemotherapy drugs** | **$0** copay | |
| **Other Part B drugs** | **$0** copay | |
| **PRESCRIPTION DRUGS** | | |
| **Medicare Part D Drugs** | See chart below for plan coverage information for prescription drugs | Medicaid may cover some drugs that are not covered by Part D. Contact the Florida Medicaid agency for questions on drug coverage.<br><br>**$0** copay for Medicaid covered prescription drugs not covered by a Medicare Prescription Drug Plan. |

**Prescription Drug Savings Benefit $0** copayment for all Medicare covered prescription drugs for all formularies, on all tiers. Benefit begins in the Deductible Stage (when applicable) and continues through Initial Coverage Stage, only. Once your total drug costs have reached **$4,430** you pay the cost-shares in the chart below. To qualify, members must be eligible for Extra Help.
**Deductible $0** if you qualify for Extra Help.

Depending on the level of Extra Help you receive, you'll pay one of the following cost-share amounts each time you fill your drug. If you do not receive Extra Help refer to your Evidence of Coverage for more details on your prescription drug benefit within Chapter 6.

| **Pharmacy options** | | |
|---|---|---|
| **Preferred cost-sharing** | **Mail order:** Humana Pharmacy®<br>**Retail:** To find the preferred cost-share retail pharmacies near you, go to **Humana.com/pharmacyfinder** | |
| **Standard cost-sharing** | **Mail order:** Walmart Mail<br>**Retail:** All other network retail pharmacies | |
| **For generic drugs** (including brand drugs treated as generic), either: | **30-day supply**<br>**$0** copay; or<br>**$1.35** copay; or<br>**$3.95** copay; or<br>**15%** of the cost | **90-day supply**<br>**$0** copay; or<br>**$1.35** copay; or<br>**$3.95** copay; or<br>**15%** of the cost |
| **For all other drugs**, either: | **$0** copay; or<br>**$4** copay; or<br>**$9.85** copay; or<br>**15%** of the cost | **$0** copay; or<br>**$4** copay; or<br>**$9.85** copay; or<br>**15%** of the cost |

Other pharmacies are available in our network.

Specialty drugs are limited to a 30-day supply.

| **ADDITIONAL DRUG COVERAGE** | |
|---|---|
| **Erectile dysfunction (ED) drugs** | This plan also provides coverage for erectile dysfunction drugs. Refer to your "Evidence of Coverage" for more information. |
| **Prescription Vitamins** | This plan also provides coverage for prescription vitamins. Refer to your “Evidence of Coverage” for more information. |

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

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

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

**Days' Supply Available**

Unless otherwise specified, you can get your Part D drug in the following days' supply amounts:
- One-month supply (up to 30 days)*

- Two-month supply (31-60 days)
- Three-month supply (61-90 days)

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

**Catastrophic Coverage**

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,050**, your share of the cost for a covered drug will be either:

- **$0** or **$3.95** for generic (including brand drugs treated as generic) and a **$0** or **$9.85** copayment for all other drugs

## Additional Benefits

| | WHAT YOU PAY ON THIS HUMANA PLAN | COMPARED TO TRADITIONAL FLORIDA MEDICAID BENEFITS (MEDICAID MANAGED CARE PLAN BENEFITS MAY BE DIFFERENT) |
|---|---|---|
| **Medicare-covered foot care (podiatry)** | **$0** copay | • **$2.00** copay per practitioner office visit, per day<br>• **$3.00** copay per federally qualified health center visit, per day<br>• **$3.00** copay per rural health clinic visit, per day |
| **Medicare-covered chiropractic services** | **$0** copay | • **$1.00** copay per provider/group, per day<br>• **$3.00** copay per federally qualified health center visit, per day<br>• **$3.00** copay per rural health clinic visit, per day |
| **MEDICAL EQUIPMENT/SUPPLIES** | | |
| **Durable medical equipment (like wheelchairs or oxygen)** | **$0** copay | **$0** copay |
| **Medical Supplies** | **$0** copay | |
| **Prosthetics (artificial limbs or braces)** | **$0** copay | |
| **Diabetic monitoring supplies** | **$0** copay | |

| | WHAT YOU PAY ON THIS HUMANA PLAN | COMPARED TO TRADITIONAL FLORIDA MEDICAID BENEFITS (MEDICAID MANAGED CARE PLAN BENEFITS MAY BE DIFFERENT) |
|---|---|---|
| **REHABILITATION SERVICES** | | |
| **Occupational and speech therapy** | **$0** to **$40** copay<br>If you are cost-share protected by the State (QMB) you pay nothing | • **$0** copay<br>• **$1500** yearly outpatient limit for respiratory, occupational, physical, and speech therapy services for adults ages 21 and older. Physical and Occupational Therapy for individuals over age 21 is limited to wheelchair evaluations<br>• **Speech Therapy**<br>– One initial AAC evaluation every five years, per recipient<br>• **Cardiac Rehab**<br>– **$2.00** copay per practitioner office visit, per day<br>– **$3.00** copay per FQHC or RHC visit, per day |
| **Cardiac rehabilitation** | **$0** to **$50** copay<br>If you are cost-share protected by the State (QMB) you pay nothing | |
| **Pulmonary rehabilitation** | **$0** to **$30** copay<br>If you are cost-share protected by the State (QMB) you pay nothing | • **$2.00** copay per practitioner office visit, per day<br>• **$3.00** copay per FQHC or RHC visit, per day |
| **TELEHEALTH SERVICES (in addition to Original Medicare)** | | |
| **Primary care provider (PCP)** | **$0** copay | |
| **Specialist** | **$0** copay | |
| **Urgent care services** | **$0** copay | |
| **Substance abuse or behavioral health services** | **$0** copay | |

# Additional Medicaid Covered Services

Dual eligible members who meet financial criteria for full Medicaid coverage may also be eligible to receive all Medicaid services not covered by Medicare. Humana Gold Plus SNP-DE H1036-245 (HMO D-SNP) may also offer coverage for these services. The benefits described in the Covered Medical and Hospital Benefits section of the Summary of Benefits are covered by Medicare. The benefits described below are covered by Medicaid. For each benefit listed below, you can see what the Florida Medicaid covers and what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility. If you have questions about your Medicaid eligibility and what benefits you are entitled to call the Florida Medicaid: 1-888-419-3456 (TTY: 711).

| BENEFIT | WHAT YOU PAY ON THIS HUMANA PLAN | MEDICAID STATE PLAN |
|---|---|---|
| **PRODUCTS AND DEVICES** | | |
| **Dentures** | See "Dental" benefit in the "Covered Medical and Hospital Benefits" chart above | • **$3.00** copayment, per visit, per day for non-emergency dental services provided in a federally qualified health center<br>• Dentures and related procedures are covered for recipients 21 years of age or older.<br>• Partial dentures must be prior authorized. |
| **Eyeglasses** | See "Vision" benefit in the "Covered Medical and Hospital Benefits" chart above | • **$0** copay<br>• For recipients age 21 years and older:<br>– One frame every two years<br>– Two lenses every 365 days |
| **Hearing Aids** | See "Hearing" benefit in the "Covered Medical and Hospital Benefits" chart above | • **$0** copay<br>• One new, hearing aid device per ear, every three years, per recipient<br>• Up to three pairs of ear molds per year, per recipient<br>• One fitting and dispensing service per ear, every three years, per recipient |
| **TRANSPORTATION** | | |
| **Non-Emergency Medical Transportation Services** | See "Transportation" benefit in the "Covered Medical and Hospital Benefits" chart above | **$0** copay to plan-approved locations |

| | | |
|---|---|---|
| **INPATIENT LONG-TERM CARE SERVICES** | | |
| **Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services in Institutions for Mental Diseases (IMD), age 65 and older** | Not covered | **$0** copay |
| **Inpatient Psychiatric Services, under age 21** | Not covered | **$0** copay |
| **Intermediate Care Facility Services for Individuals with Intellectual Disabilities** | Not Covered | **$0** copay |
| **Nursing Facility Services, other than in an Institution for Mental Diseases** | Not covered | **$0** copay |
| **Other Medicaid Covered Services** | | |
| **AIDS related Durable Medical Equipment and Medical Supplies** | Not covered | Specialized medical equipment and supplies (e.g., incontinence supplies) to enrollees with a diagnosis of AIDS, and who have had a history of an AIDS-related opportunistic infection. |
| **AIDS related Therapy Services** | Not covered | Medical massage therapy services to enrollees diagnosed with AIDS, and who have had a history of an AIDS-related opportunistic infection for the treatment of peripheral neuropathy or severe neuromuscular pain and lymphedema. |
| **Assistive Care Services** | Not covered | • **$0** copay<br>• Services must be rendered by one of the following:<br>– Assisted living facility (ALF)<br>– Adult family care homes (AFCH)<br>– Residential treatment (RTF) |

| | | |
|---|---|---|
| **Mental Health Targeted Case Management** | Not covered | • Limited to adults who have a severe and persistent mental illness and children and adolescents who have a serious emotional disturbance and are in need of service coordination among multiple providers<br>• Medicaid will reimburse:<br>Up to 344 units of mental health targeted case management per month, per recipient.<br>Up to 48 units of intensive team services per recipient, per day, per case management team.<br>Fifteen minutes equals one unit of service. If multiple units are provided on the same day, the actual time spent must be totaled and rounded to the nearest fifteen minute increment. |
| **Nursing Facility Transitional Days** | Not covered | • Member pays nothing for nursing facility transitional days for up to 120 days. Available to individuals who meet the following requirements: The member is in need of Long-Term Care services, has completed the Pre-Admission Screening and Resident Review (PASRR) requirements, is eligible for Institutional Care Program Medicaid and has not enrolled in the Long-Term Care (LTC) program |
| **Over-the-Counter (OTC) Benefits** | See "Over-the-Counter benefits" on the "More benefits with your plan" page | Select over-the-counter medications with a valid prescription. |

**HOME AND COMMUNITY BASED WAIVER SERVICES**

Dual eligible members, who meet the financial criteria for full Medicaid coverage, may also be eligible to receive Waiver services. Waiver services are limited to individuals who meet additional waiver eligibility criteria. For information on waiver services and eligibility, contact the Florida Medicaid at 1-888-419-3456 (TTY: 711).

**Exemptions. The following categories of recipients are not required to pay a copayment or coinsurance:

(a) Individuals under the age of 21 years.
(b) Pregnant women – for pregnancy – related services, including services for medical conditions that may complicate the pregnancy. This exemption includes the six week period following the end of the pregnancy.
(c) Individuals receiving services in an inpatient hospital setting, long-term care facility, or other medical institution if, as a condition of receiving services in the institution, that individual is required to spend all of his or her income for medical care costs with the exception of the minimal amount required for personal needs.
(d) Individuals who require emergency services after the sudden onset of a medical condition which, if left untreated, would place their health in serious jeopardy.
(e) Individuals receiving services or supplies related to family planning.

The Additional Medicaid Covered Services table above reflects services available on a fee for service basis for dual eligibles who meet the eligibility requirements for full Medicaid benefits.

The Medicaid information included in this section is current as of 7/1/2020. All Medicaid covered services are subject to change at any time. For the most current Florida Medicaid coverage information, please visit the Florida Medicaid website at **http://ahca.myflorida.com/** or call the Medicaid Hotline at 1-888-419-3456 (TTY: 711).

# 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.

### Healthy Foods Card

**$25** automatically loaded every month to spend at participating retailers toward the purchase of approved healthy foods.

### Special Supplemental Benefits for the Chronically Ill (SSBCI) Humana Flexible Care Assistance

Humana Flexible Care Assistance is available to chronically ill members who are participating with care management services and meet program criteria. Eligible members may receive medical expenses assistance, primarily health related, and non-primarily health related additional benefits to address specific needs based on the individual's unique situations. Benefits are limited up to **$1,000** per year and must be coordinated and authorized by a care manager. There is no cost to participate.

### 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

**$0** 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.

### Wigs (related to chemotherapy treatment)

Up to a **$500** 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 12/31/2023 based on a review of Humana's Model of Care.

Sponsored by HUMANA MEDICAL PLAN, INC. and the State of Florida, Agency For Health Care Administration.

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.

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# 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):** Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę́ niká'adoowoł.

**العربية (Arabic)**

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

Humana Gold Plus SNP-DE H1036-245
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H1036245000 ENG
Certain Panhandle Counties

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