

2025

Summary of Benefits

**Humana Group Medicare Advantage HMO Plan
HMO 076/609**

State of Florida

Department of
**MANAGEMENT
SERVICES**
Division of State Group Insurance



Humana®

Our service area includes the following: **Florida:** Alachua, Baker, Bay, Bradford, Broward, Charlotte, Citrus, Clay, Collier, Columbia, DeSoto, Duval, Escambia, Flagler, Glades, Hardee, Hernando, Highlands, Hillsborough, Indian River, Lake, Lee, Manatee, Marion, Martin, Miami-Dade, Nassau, Okaloosa, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Putnam, Santa Rosa, Sarasota, Seminole, St. Johns, St. Lucie, Sumter, Volusia, Walton.



Let's talk about the **Humana Group Medicare Advantage HMO Plan.**

Find out more about the Humana Group Medicare Advantage HMO plan – including the services it covers – in this easy-to-use guide.

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, refer to the "Evidence of Coverage".

To be eligible

To join the Humana Group Medicare Advantage HMO plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Humana Group Medicare Advantage HMO plan has a network of doctors, hospitals, and other providers. For more information, please call Humana Group Medicare Customer Care.

Plan name:

Humana Group Medicare Advantage HMO plan



A healthy partnership

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

How to reach us:

Members should call toll-free
1-800-555-7997 for questions
(TTY/TDD 711)

Call Monday – Friday, 8 a.m. - 9 p.m.
Eastern Time.

Or visit our website:
<https://your.Humana.com/sof>



Monthly Premium, Deductible and Limits

IN-NETWORK

PLAN COSTS

Monthly premium

You must keep paying your Medicare Part B premium.

For information concerning the actual premiums you will pay, please contact your employer group benefits plan administrator.

Medical deductible

This plan does not have a deductible.

Maximum out-of-pocket responsibility

The most you pay for copays, coinsurance and other costs for medical services for the year.

In-Network Maximum Out-of-Pocket

\$1,000 out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; Dental Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; OTC Drugs and Supplies; Podiatry Services (Routine); Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Transportation (Routine); Vision Services (Routine) and the Plan Premium do not apply to the in-network maximum out-of-pocket.

If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.

Note: A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.



Covered Medical and Hospital Benefits

IN-NETWORK

ACUTE INPATIENT HOSPITAL CARE

This plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

\$100 per admit

OUTPATIENT HOSPITAL COVERAGE

Outpatient hospital visits **\$0 to \$10** copay

Observation services **\$0** copay

Ambulatory surgical center **\$0** copay

DOCTOR OFFICE VISITS

Primary care provider (PCP) **\$0** copay

Specialists **\$10** copay

PREVENTIVE CARE

Including: Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Any additional preventive services approved by Medicare during the contract year will be covered.

Covered at no cost

EMERGENCY CARE

Emergency room **\$65** copay for Medicare-covered emergency room visit(s)

If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.

Urgently needed services **\$0 to \$10** copay

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

DIAGNOSTIC SERVICES, LABS AND IMAGING

Diagnostic radiology **\$0 to \$10** copay

Lab services **\$0** copay

Note: A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.



Covered Medical and Hospital Benefits

IN-NETWORK

Diagnostic tests and procedures \$0 to \$10 copay

Outpatient x-rays \$0 to \$10 copay

Radiation therapy \$10 copay

HEARING SERVICES

Medicare-covered hearing: diagnostic hearing and balance exams \$10 copay

Routine hearing \$0 copay for fitting/evaluation, routine hearing exams up to 1 per year. \$500 maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year.
HearUSA provider must be used. Contact Customer Service to locate a provider.
Note: Includes 1 month battery supply and 2 year warranty.

DENTAL SERVICES

Medicare-covered dental \$10 copay (services include surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease)

Routine dental
0% of the cost for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.
0% of the cost for panoramic film or diagnostic x-rays up to 1 every 5 years.
0% of the cost for bitewing x-rays up to 1 set(s) per year.
0% of the cost for emergency diagnostic exam, intraoral x-rays up to 1 per year.
0% of the cost for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year.
0% of the cost for periodontal maintenance up to 4 per year.
0% of the cost for general anesthesia (nitrous oxide, anxiolysis, intravenous-conscious-sedation/analgesia) up to unlimited per year.
20% of the cost for amalgam and/or composite filling, emergency treatment for pain up to 2 per year.
20% of the cost for simple or surgical extraction up to unlimited per year.
50% of the cost for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.
50% of the cost for occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years.
50% of the cost for complete dentures, partial dentures up to 1 set(s) every 5 years.
50% of the cost for adjustments to dentures, denture rebase, denture reline, denture repair, root canal or retreatment, tissue conditioning up to 1 per year.
50% of the cost for crown, oral surgery up to 2 per year.
50% of the cost for other restorative services - core buildup and prefabricated post and core up to 1 per tooth per lifetime.

Note: A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.



Covered Medical and Hospital Benefits

IN-NETWORK

\$1,000 maximum benefit coverage amount per year for all preventive and comprehensive benefits.

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 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 coinsurance payment still applies).

The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. Contact Customer Service to locate a provider.

VISION SERVICES

Medicare-covered vision services	\$10 copay (services include diagnosis and treatment of diseases and injuries of the eye)
Medicare-covered diabetic eye exam (1 per year)	\$0 copay
Medicare-covered glaucoma screening (1 per year)	\$0 copay
Medicare-covered eyewear (post-cataract)	\$0 copay
Routine vision	\$0 copay for routine exam (includes refraction) up to 1 per year.

EyeMed is the In-Network provider for the routine vision benefit. Contact Customer Service to locate a provider.

Note: A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.



Covered Medical and Hospital Benefits

IN-NETWORK

MENTAL HEALTH SERVICES

Inpatient**\$100** per admit

The inpatient hospital care limit applies to inpatient mental services provided in a general hospital or a psychiatric facility. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
190 day lifetime limit in a psychiatric facility.

Outpatient group and individual therapy visits

Outpatient therapy visit:
\$0 to \$10 copay
Partial Hospitalization:
\$0 copay

SKILLED NURSING FACILITY

This plan covers up to 100 days in a SNF. **\$0** copay per day for days 1-100

No 3-day hospital stay is required.
Plan pays \$0 after 100 days.

PHYSICAL THERAPY

\$5 to \$10 copay

AMBULANCE

Per date of service regardless of the number of trips. Limited to Medicare-covered transportation. **\$0** copay

TRANSPORTATION

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

PART B PRESCRIPTION DRUGS

Medicare Part B covered drugs **0% to 20%** of the cost**Medicare Part B insulin drugs** **0% to 20%** of the cost

You will pay no more than \$35 for a one-month (up to 30-day) supply for all Part B insulin covered by our plan, and if your plan has a deductible it does not apply to Part B insulin.

Note: A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.



Covered Medical and Hospital Benefits

IN-NETWORK

ACUPUNCTURE SERVICES

Medicare-covered acupuncture visit(s) for chronic low back pain	\$10 copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.
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This plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements.

ALLERGY

Allergy shots & serum	\$0 copay
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CHIROPRACTIC SERVICES

Medicare-covered chiropractic visit(s)	\$10 copay
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DIABETES MANAGEMENT TRAINING

	\$0 copay
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FOOT CARE (PODIATRY)

Medicare-covered foot care	\$10 copay
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Routine foot care	\$10 copay for routine podiatry visits up to unlimited visit(s) per year.
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HOME HEALTH CARE

	\$0 copay
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MEDICAL EQUIPMENT/SUPPLIES

Durable medical equipment (like wheelchairs or oxygen)	0% of the cost
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Medical supplies (includes but not limited to: catheters, IV set-up and supplies)	0% of the cost
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Prosthetics (artificial limbs or braces)	0% of the cost
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Diabetes monitoring supplies	\$10 copay
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Continuous glucose monitors	0% of the cost
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OUTPATIENT SUBSTANCE ABUSE

Outpatient group and individual substance abuse treatment visits	Outpatient therapy visit: \$0 to \$10 copay Partial Hospitalization: \$0 copay
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Note: A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.



Covered Medical and Hospital Benefits

IN-NETWORK

OVER-THE-COUNTER ITEMS

\$50 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products. Unused amount expires at the end of the quarter.

REHABILITATION SERVICES

Occupational and speech therapy **\$5 to \$10** copay

Cardiac rehabilitation **\$5 to \$10** copay

Pulmonary rehabilitation **\$5 to \$10** copay

RENAL DIALYSIS

Renal dialysis **\$0** copay

Kidney disease education services **\$0** copay

HUMANA IN-NETWORK TELEHEALTH VENDORS, i.e. MDLive (in addition to Original Medicare)

Primary care provider (PCP) **\$0** copay

Specialist **\$10** copay

Urgent care services **\$0** copay

Substance abuse or behavioral health services **\$0** copay

Note: A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.



Covered Medical and Hospital Benefits

IN-NETWORK

FITNESS AND WELLNESS

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

HEALTH EDUCATION SERVICES

Personal Health Coaching is an interactive inbound and outreach on-line and telephonic wellness coaching for Medicare participants who elect to participate, for wellness improvement, including weight management, nutrition, exercise, back care, blood pressure management, and blood sugar management.

MEAL BENEFIT

After a member's overnight inpatient stay in a hospital or skilled nursing facility, members are eligible for nutritious meals delivered to their door at no cost.

POST-DISCHARGE PERSONAL HOME CARE

After a member's overnight inpatient stay in a hospital or skilled nursing facility, members may receive assistance performing activities of daily living within the home. Types of assistance include bathing, dressing, toileting, walking, eating and preparing meals.

POST-DISCHARGE TRANSPORTATION SERVICES

After a member's overnight inpatient stay in a hospital or skilled nursing facility, members are provided transportation to plan approved locations by rideshare services, car, van or wheelchair accessible vehicle at no cost.

SMOKING CESSATION (ADDITIONAL)

A comprehensive smoking cessation program available online, email and phone. Personal coaches assist via establishing goals and providing articles and resources to aid in the effort to quit smoking.

HOSPICE

You must get care from a Medicare-certified hospice. You must consult with this plan before you select hospice.

Note: A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.

Notes

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 **1-877-320-1235 (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, **1-877-320-1235 (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)**.

California members:

You can also file a civil rights complaint with the California Dept. of Health Care Services, Office of Civil rights by calling **916-440-7370 (TTY: 711)**, emailing **Civilrights@dhcs.ca.gov**, or by mail at: Deputy Director, Office of Civil Rights, Department of Health Care Services, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413. Complaint forms available at: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**.

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

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 quý vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý 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 대해 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.

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 بخططنا 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**



You can see this plan's provider directory at <https://your.Humana.com/sof> or call us at the number listed at the beginning of this booklet and we will send you one.

Humana is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

If you want to compare this plan with other Medicare health plans, you can call your employer or union sponsoring this plan to find out if you have other options through them.

If you want to know more about the coverage and costs of Original Medicare, look in your 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, 7 days a week. TTY users should call 1-877-486-2048.

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<https://your.Humana.com/sof>

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