2023

Summary of Benefits

Optional Supplemental Benefits

HumanaChoice H5216-233 (PPO)

Oahu
Honolulu County

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Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-833-2364 (TTY: 711)**.

Understanding the Benefits

- [ ] The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **Humana.com/medicare** or call **1-800-833-2364 (TTY: 711)** to view a copy of the EOC.
- [ ] Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- [ ] Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- [ ] Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- [ ] 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, 2024.
- [ ] Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you may pay a higher co-pay for services received by non-contracted providers.

2023

Summary of Benefits

HumanaChoice H5216-233 (PPO)

Oahu
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Our service area includes the following county/counties in Hawaii: Honolulu.

Let's talk about HumanaChoice H5216-233 (PPO)

Find out more about the HumanaChoice H5216-233 (PPO) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice H5216-233 (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".

To be eligible

To join HumanaChoice H5216-233 (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

HumanaChoice H5216-233 (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 H5216-233 (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 H5216-233 (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

PLAN COSTS	
Monthly plan premium You must keep paying your Medicare Part B premium.	**$0**
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	No deductible for Tier 1, Tier 2 and Tier 3 **$100** for Tier 4, Tier 5
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for covered medical services for the year.	**$5,950** in-network **$8,950** combined in- and out-of-network

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
	$375 copay per day for days 1-4 **$0** copay per day for days 5-90 Your plan covers an unlimited number of days for an inpatient stay.	**20%** of the cost
OUTPATIENT HOSPITAL COVERAGE		
Outpatient surgery at outpatient hospital	**$300** copay	**40%** of the cost
Outpatient surgery at ambulatory surgical center	**$250** copay	**40%** of the cost
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**$40** copay
Specialists	**$40** copay	**$65** copay
PREVENTIVE CARE		
	Our plan covers many preventive services at no cost when you see an in-network provider including: • Abdominal aortic aneurysm screening	**$0** copay or **40%** of the cost, depending on the service and where service is provided

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from 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.

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
	• 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.	Any additional preventive services approved by Medicare during the contract year will be covered.

You do not need a referral to receive covered services from plan 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
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.	**$40** copay at an urgent care center	**$40** copay 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	**$0** copay	**40%** of the cost
Diagnostic colonoscopy	**$0** copay	**40%** of the cost
Diagnostic radiology	**$50** to **$110** copay	**40%** of the cost
Lab services	**$0** copay	**$40** to **$65** copay or **40%** of the cost
Diagnostic tests and procedures	**$0** to **$200** copay or **20%** of the cost	**$40** to **$65** copay or **40%** of the cost
Outpatient X-rays	**$0** copay	**$40** copay or **40%** of the cost
Radiation therapy	**20%** of the cost	**40%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**$40** copay	**$65** copay

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

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Routine hearing	**HER942** • **$0** copay for routine hearing exams up to 1 per year. • **$599** copay for each Advanced level hearing aid up to 1 per ear per year. • **$899** copay for each Premium level hearing aid up to 1 per ear per year. Hearing aid purchase includes: • Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models	**HER942** • **$0** copay for routine hearing exams up to 1 per year. • **$599** copay for each Advanced level hearing aid up to 1 per ear per year. • **$899** copay for each Premium level hearing aid up to 1 per ear per year. **You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (for TTY, dial 711).**
DENTAL SERVICES The cost-share indicated below is what you pay for the covered service. Additional dental benefits are available with a separate monthly premium. Please see the "Optional Supplemental Benefits" page for details.		
Medicare-covered dental	**$40** copay	**$65** copay
Routine dental Dental services are subject to our standard claims review procedures which could include dental history to approved coverage. Dental benefits under this plan may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**. Out-of-network dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefits maximums, limitations, and/or exclusions.	**DEN351** • **$0** copay for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **$0** copay for panoramic film or diagnostic x-rays up to 1 every 5 years. • **$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • **$0** copay for emergency diagnostic exam up to 1 per year. • **$0** copay for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year.	**DEN351** • **$0** copay for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **$0** copay for panoramic film or diagnostic x-rays up to 1 every 5 years. • **$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • **$0** copay for emergency diagnostic exam up to 1 per year. • **$0** copay for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year.

You do not need a referral to receive covered services from plan 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
You may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Use the HumanaDental 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 HumanaDental Medicare.	• **$0** copay for periodontal maintenance up to 4 per year. • **$0** copay for necessary anesthesia with covered service up to unlimited per year. • **$25** copay per tooth for amalgam and/or composite filling up to 2 per year. • **$1000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits.	• **$0** copay for periodontal maintenance up to 4 per year. • **$0** copay for necessary anesthesia with covered service up to unlimited per year. • **$25** copay per tooth for amalgam and/or composite filling up to 2 per year. • **$1000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
VISION SERVICES		
Medicare-covered vision services	**$40** copay	**$65** copay
Medicare-covered diabetic eye exam	**$0** copay	**40%** of the cost
Medicare-covered glaucoma screening	**$0** copay	**40%** of the cost
Medicare-covered eyewear (post-cataract)	**$0** copay	**40%** of the cost

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from 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.

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Routine vision The provider locator for routine vision can be found at **Humana.com** > Find a Doctor > select Vision care icon > Vision coverage through Medicare Advantage plans.	**VIS751** • **$0** copay for routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for routine exam. • **$100** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year.	**VIS751** • **$0** copay for routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for routine exam. • **$100** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year. • 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	**$375** copay per day for days 1-3 **$0** copay per day for days 4-90	**20%** of the cost
Outpatient group and individual therapy visits	**$40** copay	**40%** 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 **$178** copay per day for days 21-100	**40%** of the cost for days 1-100
PHYSICAL THERAPY		
	$40 copay	**40%** of the cost

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from 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
AMBULANCE		
Ambulance (ground)	**$250** copay per date of service	**$250** copay per date of service
Ambulance (air)	**20%** of the cost	**20%** of the cost
TRANSPORTATION		
	Not covered	Not covered
MEDICARE PART B DRUGS		
Chemotherapy drugs	**20%** of the cost	**40%** of the cost
Other Part B drugs	**20%** of the cost	**40%** of the cost

Prescription Drug Benefits

PRESCRIPTION DRUGS

If you don't receive Extra Help for your drugs, you'll pay the following:

Deductible No deductible for Tier 1, Tier 2 and Tier 3. This plan has a **$100** deductible for Tier 4, Tier 5 drugs. You pay the full cost of these drugs until you reach **$100**. Then, you only pay your cost-share.

Initial coverage (after you pay your deductible)

You pay the following until your total yearly drug costs reach **$4,660**. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.

Mail Order Cost-Sharing

Pharmacy options	**Standard** Walmart Mail, PillPack Other pharmacies are available in our network. To find pharmacy mail order options go to **Humana.com/pharmacyfinder**		**Preferred** CenterWell Pharmacy™	
	30-day supply	**100-day supply***	**30-day supply**	**100-day supply***
Tier 1: Preferred Generic	$10	$30	$0	$0
Tier 2: Generic	$20	$60	$0	$0
Tier 3: Preferred Brand	$47	$141	$47	$131
Tier 4: Non-Preferred Drug	$100	$300	$100	$290
Tier 5: Specialty Tier	31%	N/A	31%	N/A

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

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Retail Cost-Sharing		
Pharmacy options	**Retail** All network retail pharmacies. To find the retail pharmacies near you, go to **Humana.com/pharmacyfinder**	
	30-day supply	**100-day supply***
Tier 1: Preferred Generic	$0	$0
Tier 2: Generic	$0	$0
Tier 3: Preferred Brand	$47	$141
Tier 4: Non-Preferred Drug	$100	$300
Tier 5: Specialty Tier	31%	N/A

Your plan participates in the Insulin Savings Program. You will pay no more than $35 for a one-month (up to a 30-day) supply for Select Insulins through the first three drug payment stages (Deductible (if applicable), Initial Coverage and Coverage Gap) of the Part D benefit. The Insulin Savings Program does not apply to the Catastrophic Coverage stage. To identify which Select Insulins are included within the Insulin Savings Program, look for the ***ISP*** indicator in your Prescription Drug Guide. You are not eligible for this program if you receive "Extra Help".

Your share of the cost for Select Insulins through the Deductible Stage (if applicable), Initial Coverage Stage and Coverage Gap Stage as part of the Insulin Savings Program:

Mail Order Cost-Sharing for Select Insulins				
Pharmacy options	**Standard** Walmart Mail, PillPack Other pharmacies are available in our network. To find pharmacy mail order options, go to **Humana.com/pharmacyfinder** Walmart Mail, PillPack		**Preferred** CenterWell Pharmacy™	
	30-day supply	**100-day supply***	**30-day supply**	**100-day supply***
Tier 3: Preferred Brand	**$35**	**$105**	**$35**	**$95**

Retail Cost-Sharing for Select Insulins		
Pharmacy options	**Retail** All network retail pharmacies. To find the retail pharmacies near you, go to **Humana.com/pharmacyfinder**	
	30-day supply	**100-day supply***
Tier 3: Preferred Brand	**$35**	**$105**

If you receive Extra Help for your drugs, you'll pay the following:
Deductible You may pay **$0** or **$104** depending on your level of "Extra Help" (for Tier 4, Tier 5). If your deductible is **$104**, you pay the full cost of these drugs until you reach **$104**. Then, you only pay your cost-share.

Pharmacy cost-sharing		
For generic drugs (including brand drugs treated as generic), either:	**30-day supply**	**100-day supply***
	$0 copay; or **$1.45** copay; or **$4.15** copay ; or **15%** of the cost	**$0** copay; or **$1.45** copay; or **$4.15** copay ; or **15%** of the cost
For all other drugs, either:	**$0** copay; or **$4.30** copay; or **$10.35** copay ; or **15%** of the cost	**$0** copay; or **$4.30** copay; or **$10.35** copay ; or **15%** of the cost

Other pharmacies are available in our network.
*Some drugs are limited to a 30-day supply and others may be eligible for up to a 100-day supply

ADDITIONAL DRUG COVERAGE	
Erectile dysfunction (ED) drugs	Covered at Tier 1 cost-share amount.
Anti-Obesity drugs	Covered at Tier 2 cost-share amount.

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 your prescription drug 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 retail pharmacy.

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

Coverage Gap

After you enter the coverage gap, you pay **25 percent** of the plan's cost for covered brand name drugs and **25 percent** of the plan's cost for covered generic drugs until your out-of-pocket costs total **$7,400** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, **you may pay even less** for the following:

Tier 3 (Preferred Brand) - Select Insulin Drugs

For more information on cost sharing in the coverage gap, please call us or access your Evidence of Coverage online.

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Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,400**, you pay the greater of:

- **5%** of the cost, or
- **$4.15** copay for generic (including brand drugs treated as generic) and a **$10.35** copay for all other drugs

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
Medicare-covered foot care (podiatry)	**$40** copay	**$65** copay
Medicare-covered chiropractic services	**$20** copay	**40%** of the cost
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**20%** of the cost	**30%** of the cost
Medical Supplies	**20%** of the cost	**40%** of the cost
Prosthetics (artificial limbs or braces)	**20%** of the cost	**40%** of the cost
Diabetic monitoring supplies Cost share may vary depending on where service is provided.	**$0** copay or **10%** to **20%** of the cost	**40%** of the cost
REHABILITATION SERVICES		
Occupational and speech therapy	**$40** copay	**40%** of the cost
Cardiac rehabilitation Cost share may vary depending on the service and where service is provided.	**$40** copay	**$65** copay or **40%** of the cost
Pulmonary rehabilitation	**$20** copay	**40%** of the cost
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered
Specialist	**$40** copay	Not Covered
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered

More benefits with **your plan**

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

Travel Coverage
The PPO national network gives you in-network coverage across the country, so you can see any doctor who accepts the plan terms and conditions. You'll be able to travel with ease or split your time between locations. Visit **Humana.com** or contact Customer Care on the back of your ID card if you need help finding an in-network provider.

Acupuncture
$10 copay for acupuncture visits up to 25 visit(s) per year.

Authorization rules may apply

Routine foot care
- In-network: **$40** copay
- Out-of-network: **$65** copay
- Combined in- and out-of-network visit limit: 6 visits per year.

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

Over-the-Counter (OTC) mail order
$30 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products.
Unused quarterly funds carry over to the next quarter and expire at the end of the plan year.

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.

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Optional **Supplemental Benefits**

Customize your coverage for an extra monthly premium when you enroll. You can choose from the following to help create your Medicare plan.

$30.60

MyOption DEN204
Enhances the dental coverage already included in your Medicare Advantage plan with additional benefits for certain basic and major services at both in-network (HumanaDental Medicare network) and out-of-network dentists. These extra benefits – in addition to your basic benefits – have an additional monthly premium.

$37.70

MyOption DEN205
Enhances the dental coverage already included in your Medicare Advantage plan with additional benefits for certain basic and major services at both in-network (HumanaDental Medicare network) and out-of-network dentists. These extra benefits – in addition to your basic benefits – have an additional monthly premium.

$51.60

MyOption DEN432
Offers coverage for certain preventive, basic, and major services at both in-network (HumanaDental Medicare network) and out-of-network dentists. These extra benefits – in addition to your basic benefits – have an additional monthly premium.

Humana MyOption optional supplemental benefits (OSB) are only available to members of certain Humana Medicare Advantage (MA) plans. Members of Humana plans that offer OSBs may enroll in OSBs throughout the year. Benefits may change on January 1 each year. Enrollees must use network providers for specific OSBs when stated in the Evidence of Coverage (EOC); otherwise, covered services may be received from non-network providers at a higher cost. Enrollees must continue to pay the Medicare Part B premium, their Humana plan premium and the OSB premium.

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.

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.

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.

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2023

Optional Supplemental Benefits

HumanaChoice H5216-233 (PPO)

Oahu
Honolulu County

Humana.

My Options, My Choice
Adding Benefits to Your Plan

You're unique and have unique needs. That's why Humana offers optional supplemental benefits (OSB). For an extra monthly premium you can customize your Humana Medicare Advantage plan.

The information in this booklet will tell you about the benefits you can add to your plan. You can add these extra benefits when you sign up for your Medicare Advantage plan. You can also add these benefits after Medicare open enrollment ends on December 7 by contacting your agent or calling OSB sales at 1-888-413-7026. OSB sales is available from 8 a.m. – 8 p.m. local time, seven days a week October 1 – March 31, and Monday through Friday April 1 – September 30.

MyOption (DEN204)

The MyOption Dental benefit helps make it easy for you to plan for your dental care.

This benefit has no deductible.

Here's how the benefit works:

Monthly Premium	**$30.60**		
Maximum Benefit	Humana pays up to **$2,000** per calendar year		
Covered Dental Services	**In-Network* You Pay**	**Out-Of-Network** You Pay**	**Benefit Limitations Per Calendar Year**
Basic Dental Services (Minor Restorative)			
Amalgam restoration (silver filings)	**$25 Per tooth**	**$25 Per tooth**	Unlimited per year
Composite resin restoration (white filings)	**$25 Per tooth**	**$25 Per tooth**	
Extraction, erupted tooth or exposed root	**$25 Per tooth**	**$25 Per tooth**	Unlimited procedures per year
Surgical removal of erupted tooth	**$25 Per tooth**	**$25 Per tooth**	
Recement crown	**$25**	**$25**	One procedure every five years
Recement Denture	**$25**	**$25**	One procedure every five years
Palliative (emergency) treatment of dental pain	**$25**	**$25**	Two procedures per year
Anesthesia	**0%**	**0%**	Unlimited procedures per year
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Periodontal scaling and root planing	**$25**	**$25**	One procedure for each quadrant every three years

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations Per Calendar Year
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Scaling – moderate or severe gingival inflammation	**$25**	**$25**	One procedure every three years
Root Canal	**50%**	**50%**	One per tooth per lifetime
Root Canal retreatment	**50%**	**50%**	One per tooth per lifetime
Crowns	**50%**	**50%**	One procedure code per tooth per lifetime
Onlay	**50%**	**50%**	
Inlay – alternate benefit only	**50%**	**50%**	
Tissue conditioning – maxillary (upper) or mandibular (lower)	**50%**	**50%**	One procedure per year
Bridges	**50%**	**50%**	One procedure every five years.
Occlusal adjustment – limited	**50%**	**50%**	One procedure every three years
Occlusal adjustment – complete	**50%**	**50%**	
Oral Surgery	**50%**	**50%**	Two per year

*Network dentists have agreed to provide services at a negotiated rate. If you see a network dentist, you cannot be billed more than that rate.

Out-of-network dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. You may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Please see below for provider locator instructions.

Dental services are subject to our standard claims review procedures which could include dental history to approve coverage. Dental benefits under this plan may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**.

The Humana Optional Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at **Humana.com > Find a Doctor > Select the Dentist icon from the menu > From the distance drop down select preferred distance > Enter Zip Code > From the look up method select All Dental Networks > then select HumanaDental Medicare.**

MyOption (DEN205)

The MyOption Dental benefit helps make it easy for you to plan for your dental care.

This benefit has no deductible.

Here's how the benefit works:

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Monthly Premium	**$37.70**		
Maximum Benefit	Humana pays up to **$2,000** per calendar year		
Covered Dental Services	**In-Network* You Pay**	**Out-Of-Network** You Pay**	**Benefit Limitations Per Calendar Year**
Basic Dental Services (Minor Restorative)			
Amalgam restoration (silver filings)	**0%**	**0%**	Unlimited procedures per year
Composite resin restoration (white filings)	**0%**	**0%**	
Extraction, erupted tooth or exposed root	**0%**	**0%**	Unlimited procedures per year
Surgical removal of erupted tooth	**0%**	**0%**	
Recement inlay, onlay or partial coverage restoration	**$25**	**$25**	One procedure every five years
Recement indirectly fabricated or prefabricated post and core	**$25**	**$25**	
Recement crown	**$25**	**$25**	
Recement fixed partial denture (bridge)	**$25**	**$25**	One procedure every five years
Palliative (emergency) treatment of dental pain	**$25**	**$25**	Two procedures per year
Anesthesia	**0%**	**0%**	Unlimited procedures per year
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Periodontal scaling and root planing	**0%**	**0%**	One procedure for each quadrant every three years
Scaling – moderate or severe gingival inflammation	**0%**	**0%**	One procedure every three years
Root canal	**50%**	**50%**	One procedure per tooth per lifetime
Root canal retreatment	**50%**	**50%**	One procedure per tooth per lifetime
Crowns	**50%**	**50%**	One procedure per tooth per lifetime
Onlay	**50%**	**50%**	
Inlay – alternate benefit only	**50%**	**50%**	

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations Per Calendar Year
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Bridges - Pontic and retainer crown	**50%**	**50%**	One procedure every five years
Complete denture (including routine post-delivery care) – maxillary (upper) or mandibular (lower)	**50%**	**50%**	One upper and/or lower complete denture every five years
Immediate denture (including routine post-delivery care) – maxillary (upper) or mandibular (lower)	**50%**	**50%**	
Partial dentures (including routine post-delivery care) – resin or metal, maxillary (upper) or mandibular (lower)	**50%**	**50%**	One upper partial and/or lower partial denture every five years
Unilateral partial denture (including routine post-delivery care)	**50%**	**50%**	
Complete denture adjustment – maxillary (upper) or mandibular (lower)	**50%**	**50%**	One procedure per year
Partial denture adjustment – maxillary (upper) or mandibular (lower)	**50%**	**50%**	
Reline complete denture – maxillary (upper) or mandibular (lower)	**50%**	**50%**	One procedure per year
Reline partial denture – maxillary (upper) or mandibular (lower)	**50%**	**50%**	
Rebase complete denture – maxillary (upper) or mandibular (lower)	**50%**	**50%**	One procedure per year
Rebase partial denture – maxillary (upper) or mandibular (lower)	**50%**	**50%**	

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations Per Calendar Year
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Repair complete denture base – maxillary (upper) or mandibular (lower)	**50%**	**50%**	One procedure per year
Repair partial denture base – maxillary (upper) or mandibular (lower)	**50%**	**50%**	
Repair partial denture framework – maxillary (upper) or mandibular (lower)	**50%**	**50%**	
Replace missing or broken tooth	**50%**	**50%**	
Add tooth or clasp to partial denture	**50%**	**50%**	
Replace all teeth/acrylic – maxillary (upper) or mandibular (lower)	**50%**	**50%**	
Tissue conditioning – maxillary (upper) or mandibular (lower)	**50%**	**50%**	One procedure per year
Occlusal adjustment – limited	**50%**	**50%**	One procedure every three years
Occlusal adjustment – complete	**50%**	**50%**	
Oral surgery	**50%**	**50%**	Two procedures per year

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Dental services are subject to our standard claims review procedures which could include dental history to approve coverage. Dental benefits under this plan may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**.

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MyOption (DEN432)

This dental plan covers certain preventive, basic and major dental services. It is an extra benefit you may choose to add to your Medicare Advantage plan. However, you will have to pay an extra monthly premium for it.

In this plan, you may receive your care from either an in-network or out-of-network dentist. If you use an out-of-network dentist, your share of the cost may be higher.

Monthly Cost	
Monthly Premium	**$51.60**
Coverage Information	
Maximum plan benefit (combined in and out-of-network)	**$2,000** per calendar year
Deductible	**$0** per calendar year

You may receive the following dental services:

Plan covers up to **$2,000** allowance every year for non-Medicare covered preventive and comprehensive dental services. You are responsible for any amount above the dental coverage limit. Any amount unused at the end of the year will expire.
Your benefit can be used for most dental treatments such as:

- Preventive dental services, such as exams, routine cleanings, etc.
- Basic dental services, such as fillings, extractions, etc.
- Major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges, etc.

Note: The allowance cannot be used on cosmetic services and implants.

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Out-of-network dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. You may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Please see below for provider locator instructions.

Dental services are subject to our standard claims review procedures which could include dental history to approve coverage. Dental benefits may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**.

The Humana Optional Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at **Humana.com > Find a Doctor > Select the Dentist icon from the menu > From the Distance drop down select preferred distance > Enter zip code > From the look up method select All Dental Networks > Then select HumanaDental Medicare.**

Humana is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal. Humana MyOption Optional Supplemental Benefits (OSB) are only available to members of certain Humana Medicare Advantage (MA) plans. Members of Humana plans that offer OSBs may enroll in OSBs throughout the year. Benefits may change on January 1st each year. Enrollees must use network providers for specific OSBs when stated in the Evidence of Coverage (EOC); otherwise, covered services may be received from non-network providers at a higher cost. Enrollees must continue to pay the Medicare Part B premium, their Humana premium, and the OSB premium.

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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, ethnicity, marital status, religion, or language. 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.

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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 (TTY: 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 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다 . 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

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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 بالصحة أو جدول الأدوية 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.

Portugues: 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: 当社の健康健康保険と薬品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がありますございます。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。日本語を話す人者が支援いたします。これは無料のサービスです。

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