2023

Summary of Benefits

Optional Supplemental Benefits

Humana Gold Choice H8145-032 (PFFS)

Ohio and Indiana
Select counties in Ohio and Indiana

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

- ☐ 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

- ☐ 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, 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

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Ohio and Indiana
Select counties in Ohio and Indiana

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Our service area includes the following county/counties in Indiana: Adams, Allen, Blackford, Boone, Brown, Clark, Clay, Clinton, Crawford, Dearborn, Decatur, Dubois, Fayette, Floyd, Fountain, Franklin, Fulton, Gibson, Hamilton, Hancock, Harrison, Hendricks, Henry, Howard, Huntington, Jackson, Jay, Jefferson, Jennings, Johnson, Knox, Kosciusko, Lawrence, Madison, Marion, Marshall, Martin, Miami, Montgomery, Morgan, Newton, Noble, Ohio, Orange, Owen, Parke, Perry, Pike, Posey, Pulaski, Putnam, Randolph, Ripley, Rush, Scott, Spencer, St. Joseph, Starke, Steuben, Switzerland, Tipton, Union, Vanderburgh, Vigo, Warren, Warrick, Wells, Whitley
Ohio: Ashland, Athens, Auglaize, Butler, Champaign, Clark, Clermont, Columbiana, Coshocton, Crawford, Delaware, Fairfield, Fayette, Franklin, Greene, Hamilton, Hancock, Holmes, Knox, Licking, Logan, Mahoning, Marion, Mercer, Miami, Montgomery, Muskingum, Pickaway, Preble, Richland, Ross, Shelby, Stark, Trumbull, Tuscarawas, Union, Warren, Wayne, Wyandot.

Let's talk about Humana Gold Choice H8145-032 (PFFS)

Find out more about the Humana Gold Choice H8145-032 (PFFS) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Choice H8145-032 (PFFS) is a Medicare Advantage PFFS plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, ask us for the "Evidence of Coverage".

To be eligible

To join Humana Gold Choice H8145-032 (PFFS), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

Humana Gold Choice H8145-032 (PFFS)

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 Humana Gold Choice H8145-032 (PFFS)

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). Humana Gold Choice H8145-032 (PFFS) 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.	**$82** If you receive premium assistance, your plan premium may be reduced.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	This plan does not have a deductible.
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for covered medical services for the year.	**$6,700** combined in- and out-of-network

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
	$390 copay per day for days 1-5 **$0** copay per day for days 6-90 Your plan covers an unlimited number of days for an inpatient stay.	**30%** of the cost
OUTPATIENT HOSPITAL COVERAGE		
Outpatient surgery at outpatient hospital	**$365** copay	**$365** copay
Outpatient surgery at ambulatory surgical center	**$315** copay	**$315** copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$20** copay	**$20** copay
Specialists	**$50** copay	**$50** 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 **30%** of the cost, depending on the service and where service is provided

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	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.
EMERGENCY CARE		
Emergency room	**$90** copay	**$90** copay

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$35** copay at an urgent care center	**$35** 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	**$0** copay or **30%** of the cost
Diagnostic colonoscopy	**$0** copay	**$0** copay
Diagnostic radiology	**$180** to **$350** copay	**$180** copay or **30%** of the cost
Lab services	**$0** to **$35** copay	**$0** to **$35** copay or **30%** of the cost
Diagnostic tests and procedures	**$0** to **$110** copay	**$0** to **$50** copay or **30%** of the cost
Outpatient X-rays	**$20** to **$110** copay	**$20** to **$50** copay or **30%** of the cost
Radiation therapy	**$50** copay or **20%** of the cost	**$50** copay or **30%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**$50** copay	**$50** copay

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Routine hearing	**HER958** • **$0** copay for routine hearing exams up to 1 per year. • **$399** copay for each Standard level hearing aid up to 1 per ear per year. • **$699** copay for each Advanced level hearing aid up to 1 per ear per year. • **$999** 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	**HER958** • **$0** copay for routine hearing exams up to 1 per year. • **$399** copay for each Standard level hearing aid up to 1 per ear per year. • **$699** copay for each Advanced level hearing aid up to 1 per ear per year. • **$999** 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.		
Medicare-covered dental	**$50** copay	**$50** 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. You may be billed by the out-of-network provider for any	**DEN356** • **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. • **$0** copay for bridges, crown recementation, denture recementation, panoramic film or diagnostic x-rays up to 1 every 5 years. • **$0** copay for crown, root canal, root canal retreatment up to 1 per tooth per lifetime.	**DEN356** • **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. • **$0** copay for bridges, crown recementation, denture recementation, panoramic film or diagnostic x-rays up to 1 every 5 years. • **$0** copay for crown, root canal, root canal retreatment up to 1 per tooth per lifetime.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
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 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 emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **$0** copay for periodontal maintenance up to 4 per year. • **$0** copay for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. • **$1000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits.	• **$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 emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **$0** copay for periodontal maintenance up to 4 per year. • **$0** copay for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited 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 Additional vision benefits are available with a separate monthly premium. Please see the "Optional Supplemental Benefits" page for details.		
Medicare-covered vision services	**$50** copay	**$50** copay
Medicare-covered diabetic eye exam	**$0** copay	**$0** copay
Medicare-covered glaucoma screening	**$0** copay	**$0** copay
Medicare-covered eyewear (post-cataract)	**$0** copay	**$0** copay

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$390** copay per day for days 1-4 **$0** copay per day for days 5-90	**30%** of the cost
Outpatient group and individual therapy visits Cost share may vary depending on where service is provided.	**$40** to **$95** copay	**$40** to **$95** copay
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	**$0** copay per day for days 1-20 **$178** copay per day for days 21-100
PHYSICAL THERAPY		
Cost share may vary depending on the service and where service is provided.	**$20** to **$40** copay	**$20** copay or **30%** of the cost
AMBULANCE		
Ambulance	**$270** copay per date of service	**$270** copay per date of service
TRANSPORTATION		
	Not covered	Not covered
MEDICARE PART B DRUGS		
Chemotherapy drugs	**20%** of the cost	**20%** of the cost
Other Part B drugs	**20%** of the cost	**20%** of the cost

Prescription Drug Benefits

PRESCRIPTION DRUGS

If you don't receive Extra Help for your drugs, you'll pay the following:
Deductible This plan does not have a deductible.

Initial coverage
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	**90-day supply***	**30-day supply**	**90-day supply***
Tier 1: Preferred Generic	$10	$30	$0	$0
Tier 2: Generic	$20	$60	$5	$0
Tier 3: Preferred Brand	$47	$141	$47	$131
Tier 4: Non-Preferred Drug	$100	$300	$100	$290
Tier 5: Specialty Tier	33%	N/A	33%	N/A

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	**90-day supply***
Tier 1: Preferred Generic	$0	$0
Tier 2: Generic	$5	$15
Tier 3: Preferred Brand	$47	$141
Tier 4: Non-Preferred Drug	$100	$300
Tier 5: Specialty Tier	33%	N/A

If you receive Extra Help for your drugs, you'll pay the following:
Deductible This plan does not have a deductible.

Pharmacy cost-sharing		
For generic drugs (including brand drugs treated as generic), either:	**30-day supply**	**90-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

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Certain drugs may need advance approval before your plan will cover any of the costs. This is called "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.

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 1 (Preferred Generic) - All Drugs

Tier 2 (Generic) - All Drugs

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

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)	**$50** copay	**$50** copay
Medicare-covered chiropractic services	**$20** copay	**$20** copay
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**20%** of the cost	**20%** of the cost
Medical Supplies	**20%** of the cost	**20%** of the cost
Prosthetics (artificial limbs or braces)	**20%** of the cost	**20%** of the cost

Diabetic monitoring supplies Cost share may vary depending on where service is provided.	**$0** copay or **10%** to **20%** of the cost	**10%** to **20%** of the cost
REHABILITATION SERVICES		
Occupational and speech therapy Cost share may vary depending on the service and where service is provided.	**$20** to **$40** copay	**$20** copay or **30%** of the cost
Cardiac rehabilitation Cost share may vary depending on the service and where service is provided.	**$20** copay	**$20** copay or **30%** of the cost
Pulmonary rehabilitation Cost share may vary depending on the service and where service is provided.	**$20** copay	**$20** copay or **30%** of the cost
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered
Specialist	**$50** 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**.

Routine foot care

- In-network: **$10** copay
- Out-of-network: **$10** 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.

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.

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.

$16.10

MyOption Vision VIS757
Gives members access to the EyeMed Vision Care Select Network and provides additional vision benefits. These benefits have an additional monthly premium.

$37.10

MyOption DEN478
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.

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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.

2023

Optional Supplemental Benefits

Humana Gold Choice H8145-032 (PFFS)

Ohio and Indiana
Select counties in Ohio and Indiana

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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 Vision (VIS757)

The MyOption Vision benefit helps you plan for your vision care.

Here's how the benefit works:

Monthly Premium	**$16.10**		
Maximum Benefit	Humana pays up to **$375** for one pair of eyeglass frames and one pair of lenses **or** contact lenses (conventional or disposable) per calendar year		
Covered Vision Benefits	**In-Network You Pay**	**Out-Of-Network* You Pay**	**Benefit Limitations**
Routine exam **$40** allowance	Any amount over **$40***	Any amount over **$40**	One per year
$375 (combined in and out-of-network) benefit toward the purchase and fitting of eyeglasses and pair of lenses or contact lenses. 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. Contact lenses will include conventional or disposable. This benefit can only be used one time per plan year. Any remaining benefit dollars do not "roll over" to a future purchase.	Any amount over **$375** retail price	Any amount over **$375** retail price	One per year

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

Covered vision services are subject to conditions, limitations, exclusions, and maximums. Please see your Evidence of Coverage for details.

*Your routine eye exam charge will not exceed **$40** at an **EyeMed Vision Care Select network optical provider**. Please inform the network provider that you are part of the EyeMed Select Network.
When using an out-of-network Vision provider, you will be responsible for costs above the allowance and plan-approved amount. You are responsible for submitting an EyeMed Vision Care out-of-network claim form with itemized receipt when seeing a non-EyeMed select provider. Claim forms can be found on Humana.com or you can call EyeMed Customer service at 1-844-828-8703 Monday thru Saturday 7:30 a.m. – 11 p.m. Eastern Time and Sunday 11 a.m. – 8 p.m. Eastern Time.

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.**

MyOption (DEN478)

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	**$37.10**
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.

*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 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 PFFS 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 .

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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