

# Summary of Benefits

## Optional Supplemental Benefits

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### **HumanaChoice<sup>®</sup> H5216-174 (PPO)**

Northern New Jersey  
Bergen, Hudson and Morris counties

**Humana<sup>®</sup>**

## Pre-Enrollment Checklist

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

### Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit **Humana.com/medicare** or call **1-800-833-2364 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

### Understanding Important Rules

- ☐ You do not pay a separate monthly plan premium for this Humana plan but, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2020.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, 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.

# Summary of Benefits

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## **HumanaChoice<sup>®</sup> H5216-174 (PPO)**

Northern New Jersey  
Bergen, Hudson and Morris counties

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Our service area includes the following county/counties in New Jersey: Bergen, Hudson, Morris.



# Let's talk about HumanaChoice H5216-174 (PPO)

Find out more about the HumanaChoice H5216-174 (PPO) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice H5216-174 (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" or you will receive one after you enroll.

## To be eligible

To join HumanaChoice H5216-174 (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

## Plan name:

HumanaChoice H5216-174 (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 H5216-174 (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 H5216-174 (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

	IN-NETWORK	OUT-OF-NETWORK
<b>PLAN COSTS</b>		
<b>Monthly plan premium</b> You must keep paying your Medicare Part B premium.	<b>\$0</b>	
<b>Part B premium reduction</b>	<b>\$50</b>	
<b>Medical deductible</b>	This plan does not have a deductible.	
<b>Maximum out-of-pocket responsibility</b> The most you pay for copays, coinsurance and other costs for medical services for the year.	<b>\$4,500</b> in-network <b>\$10,000</b> combined in- and out-of-network	<b>\$10,000</b> combined in- and out-of-network



## Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>ACUTE INPATIENT HOSPITAL CARE</b>		
	<b>\$350</b> copay per day for days 1-5 <b>\$0</b> copay per day for days 6-90 Your plan covers an unlimited number of days for an inpatient stay.	<b>\$495</b> copay per day for days 1-7 <b>\$0</b> copay per day for days 8-90
<b>OUTPATIENT HOSPITAL COVERAGE</b>		
<b>Outpatient surgery at outpatient hospital</b>	<b>\$350</b> copay	<b>\$495</b> copay
<b>Outpatient surgery at ambulatory surgical center</b>	<b>\$300</b> copay	<b>\$445</b> copay
<b>DOCTOR OFFICE VISITS</b>		
<b>Primary care provider (PCP)</b>	<b>\$0</b> copay	<b>\$20</b> copay
<b>Specialists</b>	<b>\$40</b> copay	<b>\$60</b> copay
<b>PREVENTIVE CARE</b>		
	<b>Our plan covers many preventive services at no cost when you see an in-network provider including:</b> <ul style="list-style-type: none"> <li>Abdominal aortic aneurysm screening</li> <li>Alcohol misuse counseling</li> </ul>	<b>\$0</b> copay

You do not need a referral to receive covered services from 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

- 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.**

### OUT-OF-NETWORK

*You do not need a referral to receive covered services from 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
<b>EMERGENCY CARE</b>		
<b>Emergency room</b> 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.	<b>\$90</b> copay	<b>\$90</b> copay
<b>Urgently needed services</b> Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	<b>\$25</b> copay at an urgent care center	<b>\$30</b> copay at an urgent care center
<b>OUTPATIENT CARE AND DIAGNOSTIC SERVICES, LABS AND IMAGING</b> Cost share may vary depending on the service and where service is provided		
<b>Diagnostic Mammography</b>	<b>\$40</b> to <b>\$90</b> copay	<b>\$60</b> to <b>\$110</b> copay
<b>Diagnostic radiology</b>	<b>\$0</b> to <b>\$350</b> copay	<b>\$20</b> to <b>\$495</b> copay
<b>Lab services</b>	<b>\$0</b> to <b>\$40</b> copay	<b>\$0</b> to <b>\$60</b> copay
<b>Diagnostic tests and procedures</b>	<b>\$0</b> to <b>\$90</b> copay	<b>\$20</b> to <b>\$110</b> copay
<b>Outpatient X-rays</b>	<b>\$0</b> to <b>\$90</b> copay	<b>\$20</b> to <b>\$110</b> copay
<b>Radiation Therapy</b>	<b>20%</b> of the cost	<b>20%</b> of the cost
<b>HEARING SERVICES</b>		
<b>Medicare covered hearing</b>	<b>\$40</b> copay	<b>\$60</b> copay
<b>DENTAL SERVICES</b> 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.		
<b>Medicare covered dental</b>	<b>\$40</b> copay	<b>\$60</b> copay
<b>Routine dental DEN978</b>  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.	<ul style="list-style-type: none"> <li>• <b>0%</b> coinsurance for perio exam up to 1 every 3 years</li> <li>• <b>0%</b> coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years</li> <li>• <b>0%</b> coinsurance for bitewing x-rays up to 1 set per year.</li> <li>• <b>0%</b> coinsurance for intraoral x-rays up to 1 per year</li> <li>• <b>0%</b> coinsurance for fluoride, periodic oral exam and/or comprehensive oral evaluation,</li> </ul>	<ul style="list-style-type: none"> <li>• <b>50%</b> coinsurance for perio exam up to 1 every 3 years</li> <li>• <b>50%</b> coinsurance for panoramic film or diagnostic x-ray up to 1 every 5 years</li> <li>• <b>50%</b> coinsurance for bitewing x-ray up to 1 set per year</li> <li>• <b>50%</b> coinsurance for intraoral x-rays up to 1 per year</li> <li>• <b>50%</b> coinsurance for fluoride, periodic oral exam and/or comprehensive oral evaluation,</li> </ul>

You do not need a referral to receive covered services from 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
	prophylaxis (cleaning) up to 2 per year • <b>0%</b> coinsurance for necessary anesthesia with covered service up to unlimited per year • <b>50%</b> coinsurance for amalgam and/or composite filling, simple or surgical extraction up to 2 per year • <b>70%</b> coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years • <b>70%</b> coinsurance for perio maintenance up to 2 per year • <b>\$2000</b> combined maximum benefit coverage amount per year	prophylaxis (cleaning) up to 2 per year • <b>50%</b> coinsurance for necessary anesthesia with covered service up to unlimited per year • <b>55%</b> coinsurance for amalgam and/or composite filling, simple or surgical extraction up to 2 per year • <b>75%</b> coinsurance for scaling and root planning (deep cleaning) up to 1 per quadrant every 3 years • <b>75%</b> coinsurance for perio maintenance up to 2 per year • <b>\$2000</b> combined maximum benefit coverage amount per year • Benefits received out-of-network are subject to any in-network benefit maximums, limits, and/or exclusions
<b>VISION SERVICES</b>		
<b>Medicare covered vision services</b>	<b>\$40</b> copay	<b>\$60</b> copay
<b>Diabetic Eye Exam</b>	<b>\$0</b> copay	<b>\$60</b> copay
<b>Glaucoma screening</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>Eyewear (post-cataract)</b>	<b>\$0</b> copay	<b>\$0</b> copay

You do not need a referral to receive covered services from 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
<b>Routine vision VIS752</b>  The provider locator can be found at Humana.com > Find a Doctor > from the Search Type drop down select Vision > Eyemed Select Network.	<ul style="list-style-type: none"> <li>• <b>\$75</b> maximum benefit coverage amount per year for routine exam, refraction up to 1 per year.</li> <li>• <b>\$200</b> maximum benefit coverage amount per year for contact lenses or eyeglasses - lenses and frames (includes fitting). Eyeglasses will include ultraviolet protection and scratch resistant coating.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>\$75</b> maximum benefit coverage amount per year for routine exam, refraction up to 1 per year.</li> <li>• <b>\$200</b> maximum benefit coverage amount per year for contact lenses or eyeglasses - lenses and frames (includes fitting). Eyeglasses will include ultraviolet protection and scratch resistant coating.</li> <li>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.</li> </ul>
<b>MENTAL HEALTH SERVICES</b>		
<b>Inpatient</b> Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	<b>\$324</b> copay per day for days 1-5 <b>\$0</b> copay per day for days 6-90	<b>\$495</b> copay per day for days 1-7 <b>\$0</b> copay per day for days 8-90
<b>Outpatient group and individual therapy visits</b> Cost share may vary depending on where service is provided.	<b>\$40 to \$70</b> copay	<b>\$60 to \$110</b> copay
<b>SKILLED NURSING FACILITY (SNF)</b>		
Your plan covers up to 100 days in a SNF	<b>\$0</b> copay per day for days 1-20 <b>\$172</b> copay per day for days 21-100	<b>20%</b> of the cost
<b>PHYSICAL THERAPY</b>		
	<b>\$40</b> copay	<b>\$60</b> copay
<b>AMBULANCE</b>		
<b>Ambulance (ground)</b>	<b>\$265</b> per date of service	<b>\$265</b> per date of service
<b>TRANSPORTATION</b>		
	Not covered	Not covered

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



## Prescription Drug Benefits

### MEDICARE PART B DRUGS

<b>Chemotherapy drugs</b>	<b>20%</b> of the cost	<b>20%</b> of the cost
<b>Other part B drugs</b>	<b>20%</b> of the cost	<b>20%</b> of the cost

### PRESCRIPTION DRUGS

Your plan covers Part B drugs including, but not limited to, chemotherapy and some drugs administered by your provider. However, this plan does not cover Part D prescription drugs.



## Additional benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>Medicare-covered foot care (podiatry)</b>	<b>\$40</b> copay	<b>\$60</b> copay
<b>Medicare-covered chiropractic services</b>	<b>\$0</b> copay	<b>\$20</b> copay
<b>MEDICAL EQUIPMENT/SUPPLIES</b>		
<b>Durable medical equipment (like wheelchairs or oxygen)</b>	<b>20%</b> of the cost	<b>20%</b> of the cost
<b>Medical Supplies</b>	<b>20%</b> of the cost	<b>20%</b> of the cost
<b>Prosthetics (artificial limbs or braces)</b>	<b>20%</b> of the cost	<b>20%</b> of the cost
<b>Diabetic monitoring supplies</b> Cost share may vary depending on where service is provided.	<b>\$0</b> copay or <b>10%</b> to <b>20%</b> of the cost	<b>20%</b> of the cost
<b>REHABILITATION SERVICES</b>		
<b>Physical, occupational and speech therapy</b>	<b>\$40</b> copay	<b>\$60</b> copay
<b>Cardiac rehabilitation</b>	<b>\$30</b> copay	<b>\$60</b> copay
<b>Pulmonary rehabilitation</b>	<b>\$30</b> copay	<b>\$60</b> copay



## More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

### **Travel Coverage**

As a member of a HumanaChoice (PPO), you have the benefit to use Humana's network of providers across the U.S. (not available in all counties). If you are visiting another HumanaChoice (PPO) service area, simply access a Humana network provider to receive your in-network level of benefits for up to twelve consecutive months. You pay your in-network copay or coinsurance when you visit a participating provider for non-emergency care, including preventive care, specialist care and hospitalizations. Visit **Humana.com** or contact Customer Care on the back of your ID card if you need help finding an in-network provider.

### **Well Dine Meal Program**

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

### **HumanaFirst® Nurse Hotline**

Health advice from a registered nurse, available 24 hours a day, seven days a week.

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

Up to **\$45** allowance every 3 months for the purchase of OTC supplies from Humana Pharmacy mail delivery.

### **Virtual Visits - Medical**

Access to doctors and other practitioners via phone and/or video technology for diagnosis and treatment of certain non-emergency medical issues.

You pay a **\$10** copay to receive a remote medical consultation.

### **Virtual Visits – Mental and Behavioral Health**

Access to doctors and other mental health professionals via phone and/or video technology for diagnosis and treatment of certain non-emergency mental or behavioral issues.

You pay a **\$20** copay to receive a remote mental and behavioral consultation.

### **Go365™ by Humana**

Rewards 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.

**\$32.50**

### **MyOption Total Dental DEN984**

Enhances the dental coverage already included in your Medicare Advantage plan with additional benefits 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**

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You can see our plan's **provider directory** at our website at **[www.humana.com/members/tools](http://www.humana.com/members/tools)** or call us at the number listed at the beginning of this booklet and we will send you one.

This information is not a complete description of benefits. Call 1-800-457-4708 (TTY: 711) for more information.

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.

**This information is available in a different format**, including Braille, large print, and audio tapes. Please call Customer Care at the number listed in the beginning of this document if you need plan information in another format.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-833-2364 (TTY: 711).

The provider network may change at any time. You will receive notice when necessary.

Limitations on healthcare and prescription services delivered via virtual visits and communications options vary by state. Virtual visit services are not a substitute for emergency care and not intended to replace your primary care provider or other providers in your network. This material is provided for informational use only and should not be construed as medical advice or used in place of consulting a licensed medical professional.

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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# Optional Supplemental Benefits

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**H5216-174 (PPO)**

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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.

You can add these extra benefits when you sign up for your Medicare Advantage plan or any time during the year.

The information in this booklet will tell you about the benefits you can add to your plan. If you have questions, you can call us at 1-888-866-3154 (TTY: 711). We are available seven days a week, from 8 a.m. - 8 p.m. local time. However, please note that our automated phone system may answer your call during weekends and holidays from April 1 - September 30. Please leave your name and telephone number, and we will call you back by the end of the next business day.

## MyOption<sup>SM</sup> Total Dental (DEN984)

The MyOption<sup>SM</sup> Total Dental benefit helps make it easy for you to plan for your dental care.

Here's how the benefit works:

<b>Monthly Premium</b>	<b>\$32.50</b>		
<b>Maximum Benefit</b>	Humana pays up to <b>\$2,000</b> per calendar year		
<b>Covered Dental Services</b>	<b>In-Network* You Pay</b>	<b>Out-Of-Network** You Pay</b>	<b>Benefit Limitations Per Calendar Year</b>
<b>Preventive and Diagnostic Dental Services</b>			
Oral examinations	<b>0%</b>	<b>50%</b>	Two per year
Periodontal exam	<b>0%</b>	<b>50%</b>	One every three years
Dental prophylaxis (cleanings)	<b>0%</b>	<b>50%</b>	Two per year
Panoramic or Diagnostic X-rays	<b>0%</b>	<b>50%</b>	One set per year
Intraoral X-ray	<b>0%</b>	<b>50%</b>	One set per year
Bitewing X-ray	<b>0%</b>	<b>50%</b>	One set per year
Fluoride treatment	<b>0%</b>	<b>50%</b>	Two per year
<b>Basic Dental Services (Minor Restorative)</b>			
Amalgam (silver) restorations (fillings)	<b>50%</b>	<b>55%</b>	Two per year
Composite resin restorations (white fillings)	<b>50%</b>	<b>55%</b>	
Extractions (pulling teeth), simple or surgical	<b>50%</b>	<b>55%</b>	Two per year



## OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of- Network** You Pay	Benefit Limitations Per Calendar Year
<b>Basic Dental Services (Minor Restorative)</b>			
Recementation	<b>70%</b>	<b>75%</b>	One procedure every five years
Emergency treatment for pain	<b>50%</b>	<b>55%</b>	Two per year
Anesthesia	<b>0%</b>	<b>50%</b>	Unlimited procedures per year
<b>Major Dental Services (Endodontics, Periodontics, and Oral Surgery)</b>			
Periodontal maintenance	<b>70%</b>	<b>75%</b>	Two per year
Periodontal scaling and root planing (deep cleaning)	<b>70%</b>	<b>75%</b>	One procedure for each quadrant per year
Root canal treatment	<b>70%</b>	<b>75%</b>	One per year
Crowns	<b>70%</b>	<b>75%</b>	Two per year
Oral surgery	<b>70%</b>	<b>75%</b>	Two per year
Complete dentures (including routine post-delivery care)	<b>70%</b>	<b>75%</b>	One upper and/or one lower complete denture every five years
Partial dentures	<b>70%</b>	<b>75%</b>	One upper and/or one lower partial denture every five years
Denture adjustments (not covered within six months of initial placement)	<b>70%</b>	<b>75%</b>	One per year
Denture reline (not allowed on spare dentures)	<b>70%</b>	<b>75%</b>	One per year

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

\*Network dentists have agreed to provide services at an in-network rate. If you see a network dentist, you can't be billed more than the in-network rate.

\*\*If you use an out-of-network dentist, your share of the cost may be higher.

The Humana Optional Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at [Humana.com](https://www.humana.com) > Find a Doctor > from the Search Type drop down select Dental > 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 1<sup>st</sup> 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.

**Humana<sup>®</sup>**

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## This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There is no handwriting or other markings on the paper.

## Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion.

Humana Inc. and its subsidiaries provide: (1) 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; and, (2) free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call **1-877-320-1235** or if you use a **TTY**, call **711**.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion, you can file a grievance with 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 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, 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>**.

## Multi-Language Interpreter Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-877-320-1235 **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-1235 **(TTY: 711)** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-320-1235 **(TTY: 711)**。... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-320-1235 **(TTY: 711)**... 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-320-1235 **(TTY: 711)** 번으로 전화해 주십시오 .... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-320-1235 **(TTY: 711)**... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-320-1235 **(телетайп: 711)**... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-320-1235 **(TTY: 711)**... ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-320-1235 **(ATS: 711)**... UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-320-1235 **(TTY: 711)**... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-320-1235 **(TTY: 711)**... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-320-1235 **(TTY: 711)**... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-320-1235 **(TTY: 711)**... 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-877-320-1235 **(TTY: 711)** まで、お電話にてご連絡ください。 ...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. 1-877-320-1235 **(TTY: 711)** تماس بگیرید.

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hólq, kóji' hódíłnih 1-877-320-1235 **(TTY: 711)**...

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-320-1235 **(رقم هاتف الصم والبكم: 711)**.





HumanaChoice H5216-174 (PPO)  
H5216174000 ENG  
Bergen, Hudson and Morris counties

