

# Summary of Benefits

## Optional Supplemental Benefits

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### **HumanaChoice<sup>®</sup> R4845-002 (Regional PPO)**

Region 18  
States of Kansas and Oklahoma

Our service area includes the following state(s): Kansas, Oklahoma.

**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.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

### Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 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.

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# Let's talk about HumanaChoice R4845-002 (Regional PPO)

Find out more about the HumanaChoice R4845-002 (Regional PPO) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice R4845-002 (Regional 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 R4845-002 (Regional PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

## Plan name:

HumanaChoice R4845-002 (Regional 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 R4845-002 (Regional 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 R4845-002 (Regional 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>\$99</b>	
<b>Medical deductible</b>		<b>\$500</b> combined in- and out-of-network All services received from in network providers are excluded from the combined deductible. Services not covered by Original Medicare, Ambulance services, Emergency room services, Urgently Needed Services at Urgent Care Centers, Immunizations (Flu & Pneumonia) received from out-of-network providers are also excluded from the combined deductible.
<b>Pharmacy (Part D) deductible</b>	<b>\$415</b> for Tier 3, Tier 4, Tier 5.	
<b>Maximum out-of-pocket responsibility</b> The most you pay for copays, coinsurance and other costs for medical services for the year.	<b>\$6,700</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>\$360</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>40%</b> of the cost
<b>OUTPATIENT HOSPITAL COVERAGE</b>		
<b>Outpatient surgery at outpatient hospital</b>	<b>25%</b> of the cost	<b>40%</b> of the cost
<b>Outpatient surgery at ambulatory surgical center</b>	<b>20%</b> of the cost	<b>40%</b> of the cost

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>DOCTOR OFFICE VISITS</b>		
<b>Primary care provider (PCP)</b>	<b>\$20</b> copay	<b>40%</b> of the cost
<b>Specialists</b>	<b>\$50</b> copay	<b>40%</b> of the cost
<b>PREVENTIVE CARE</b>		
	<p><b>Our plan covers many preventive services at no cost when you see an in-network provider including:</b></p> <ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening</li> <li>• Alcohol misuse counseling</li> <li>• Bone mass measurement</li> <li>• Breast cancer screening (mammogram)</li> <li>• Cardiovascular disease (behavioral therapy)</li> <li>• Cardiovascular screenings</li> <li>• Cervical and vaginal cancer screening</li> <li>• Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</li> <li>• Depression screening</li> <li>• Diabetes screenings</li> <li>• HIV screening</li> <li>• Medical nutrition therapy services</li> <li>• Obesity screening and counseling</li> <li>• Prostate cancer screenings (PSA)</li> <li>• Sexually transmitted infections screening and counseling</li> <li>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>• Vaccines, including flu shots, hepatitis B shots, pneumococcal shots</li> <li>• "Welcome to Medicare" preventive visit (one-time)</li> <li>• Annual Wellness Visit</li> <li>• Lung cancer screening</li> <li>• Routine physical exam</li> </ul>	<p><b>\$0</b> or <b>40%</b> of the cost, depending on the service and where service is provided</p>

*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

- Medicare diabetes prevention program

**Any additional preventive services approved by Medicare during the contract year will be covered.**

### 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.

**\$30** copay at an urgent care center

**40%** of the cost 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

**\$50** copay or **20%** to **25%** of the cost

**40%** of the cost

##### Diagnostic radiology

**\$180** to **\$360** copay

**40%** of the cost

##### Lab services

**\$0** to **\$45** copay

**40%** of the cost

##### Diagnostic tests and procedures

**\$0** to **\$50** copay or **25%** of the cost

**40%** of the cost

##### Outpatient X-rays

**\$20** to **\$100** copay

**40%** of the cost

##### Radiation Therapy

**\$50** or **20%** of the cost

**40%** of the cost

#### HEARING SERVICES

##### Medicare covered hearing

**\$50** copay

**40%** of the cost

#### DENTAL SERVICES

Additional dental benefits are available with a separate monthly premium. Please see the "Optional Supplemental Benefits" page for details.

##### Medicare covered dental

**\$50** copay

**40%** of the cost

#### 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

**40%** of the cost

*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>Diabetic Eye Exam</b>	<b>\$0</b> copay	<b>40%</b> of the cost
<b>Glaucoma screening</b>	<b>\$0</b> copay	<b>40%</b> of the cost
<b>Eyewear (post-cataract)</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>Routine vision VIS775</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>\$0</b> copayment for routine exam, refraction up to 1 per year.</li> <li>• <b>\$40</b> combined maximum benefit coverage amount per year for refraction, routine exam.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>\$0</b> copayment for routine exam, refraction up to 1 per year.</li> <li>• <b>\$40</b> combined maximum benefit coverage amount per year for refraction, routine exam.</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>\$318</b> copay per day for days 1-5 <b>\$0</b> copay per day for days 6-90	<b>40%</b> of the cost
<b>Outpatient group and individual therapy visits</b> Cost share may vary depending on where service is provided.	<b>\$40 to \$50</b> copay or <b>25%</b> of the cost	<b>40%</b> of the cost
<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>\$167.50</b> copay per day for days 21-100	<b>40%</b> of the cost
<b>PHYSICAL THERAPY</b>		
Cost share may vary depending on the service and where service is provided.	<b>\$30 to \$40</b> copay	<b>40%</b> of the cost
<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>40%</b> of the cost
<b>Other part B drugs</b>	<b>20%</b> of the cost	<b>20%</b> of the cost

## PRESCRIPTION DRUGS

**Deductible** This plan has a **\$415** deductible for Tier 3, Tier 4, Tier 5 drugs. You pay the full cost of these drugs until you reach \$415. Then, you only pay your cost-share.

**Initial coverage** (after you pay your deductible, if applicable)

You pay the following until your total yearly drug costs reach **\$3,820**. 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.

### Preferred cost-sharing

Pharmacy options	Retail To find the preferred cost-share retail pharmacies near you, go to <b>Humana.com/pharmacyfinder</b>		Mail order Humana Pharmacy®	
	30-day supply	90-day supply	30-day supply	90-day supply
<b>Tier 1:</b> Preferred Generic	\$2	\$6	\$2	\$0
<b>Tier 2:</b> Generic	\$9	\$27	\$9	\$0
<b>Tier 3:</b> Preferred Brand	\$47	\$141	\$47	\$131
<b>Tier 4:</b> Non-Preferred Drug	\$100	\$300	\$100	\$290
<b>Tier 5:</b> Specialty Tier	25%	N/A	25%	N/A

### Standard cost-sharing

Pharmacy options	Retail All other network retail pharmacies.		Mail order Walmart Mail	
	30-day supply	90-day supply	30-day supply	90-day supply
<b>Tier 1:</b> Preferred Generic	\$10	\$30	\$10	\$30
<b>Tier 2:</b> Generic	\$20	\$60	\$20	\$60
<b>Tier 3:</b> Preferred Brand	\$47	\$141	\$47	\$141
<b>Tier 4:</b> Non-Preferred Drug	\$100	\$300	\$100	\$300
<b>Tier 5:</b> Specialty Tier	25%	N/A	25%	N/A

Generic drugs may be covered on tiers other than Tier 1 and Tier 2 so please check this plan's Humana Drug List to validate the specific tier on which your drugs are covered.

Specialty drugs are limited to a 30 day supply.

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

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

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

### Days' Supply Available

Unless otherwise specified, you can get your Part D drug in the following days' supply amounts:

- One month supply (up to 30 days)\*
- Two month supply (31-60 days)
- Three month supply (61-90 days)

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

### Coverage Gap

After you enter the coverage gap, you pay **25 percent** of the plan's cost for covered brand name drugs and **37 percent** of the plan's cost for covered generic drugs until your costs total **\$5,100** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

### Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **\$5,100**, you pay the greater of:

- **5%** of the cost, or
- **\$3.40** copay for generic (including brand drugs treated as generic) and a **\$8.50** copayment for all other drugs



### Additional benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>Medicare-covered foot care (podiatry)</b>	<b>\$50</b> copay	<b>40%</b> of the cost
<b>Medicare-covered chiropractic services</b>	<b>\$20</b> copay	<b>40%</b> of the cost
<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
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#### REHABILITATION SERVICES

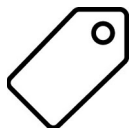
<b>Physical, occupational and speech therapy</b>	<b>\$30</b> to <b>\$40</b> copay	<b>40%</b> of the cost
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Cost share may vary depending on the service and where service is provided.

<b>Cardiac rehabilitation</b>	<b>\$20</b> or <b>25%</b> of the cost	<b>40%</b> of the cost
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Cost share may vary depending on the service and where service is provided.

<b>Pulmonary rehabilitation</b>	<b>\$30</b> copay	<b>40%</b> of the cost
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## 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 **\$25** 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.

### **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.

**\$23.70**

### **MyOption Platinum Dental DEN887**

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

**\$15.30**

### **MyOption Vision VIS757**

Gives members access to the EyeMed Vision Care Select Network and provides additional vision benefits. These extra benefits - in addition to their 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 **[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.



You can see our plan's **drug list** at our website at **[www.humana.com/medicare/medicare\\_prescription\\_drugs/medicare\\_drug\\_tools/medicare\\_drug\\_list/](http://www.humana.com/medicare/medicare_prescription_drugs/medicare_drug_tools/medicare_drug_list/)** 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/pharmacy 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.





2019

# Optional Supplemental Benefits

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**HumanaChoice<sup>®</sup>**  
**R4845-002 (Regional PPO)**

Region 18  
States of Kansas and Oklahoma

**Humana<sup>®</sup>**

## 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> Platinum Dental (DEN887)

The MyOption<sup>SM</sup> Platinum Dental benefit helps you plan for your dental care. This benefit has no deductible and pays the full cost for two routine exams per year with an in-network provider.

Here's how the benefit works:

<b>Monthly Premium</b>	<b>\$23.70</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 procedure every three years
Dental prophylaxis (cleanings)	<b>0%</b>	<b>50%</b>	Two per year
Fluoride treatment	<b>0%</b>	<b>50%</b>	Two per year
Bitewing X-ray	<b>0%</b>	<b>50%</b>	One set per year
Intraoral X-ray	<b>0%</b>	<b>50%</b>	One set per year
Panoramic or diagnostic X-rays	<b>0%</b>	<b>50%</b>	One set per year
<b>Basic Dental Services (Minor Restorative)</b>			
Amalgam restorations (silver fillings)	<b>50%</b>	<b>55%</b>	Two per year
Composite resin restorations (white fillings)	<b>50%</b>	<b>55%</b>	

## 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>			
Extractions (pulling teeth), simple or surgical	<b>50%</b>	<b>55%</b>	Two per year
Recementation	<b>50%</b>	<b>55%</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 per calendar year
<b>Major Dental Services (Endodontics, Periodontics, and Oral Surgery)</b>			
Root canal treatment	<b>70%</b>	<b>75%</b>	One per year
Crowns	<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
Periodontal maintenance	<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
Oral surgery	<b>70%</b>	<b>75%</b>	Two 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 see an out-of-network dentist, your share of the cost may be higher.

The Humana Optional Supplemental Dental benefits are provided through the HumanaDental 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.

## OPTIONAL SUPPLEMENTAL BENEFITS (continued)

### MyOption<sup>SM</sup> Vision (VIS757)

The MyOption<sup>SM</sup> Vision benefit helps you plan for your vision care.

Here's how the benefit works:

Monthly Premium	\$15.30		
Maximum Benefit	Humana pays up to <b>\$375</b> for one set of eyeglass frames and one pair of lenses <b>or</b> contact lenses (conventional or disposable) per calendar year		
Covered Vision Benefits	EyeMed Select Network Vision Provider You Pay	Non-EyeMed Select Network Vision Provider You Pay	Benefit Limitations
Routine exam with refraction/dilation as necessary - <b>\$40*</b> allowance	<b>\$0</b>	Any amount over <b>\$40</b>	One per year
<b>\$375</b> (combined in and out-of-network) benefit toward the purchase of frames and lenses, including fitting or contact lenses.  Eyeglasses will include ultraviolet protection and scratch resistance coating.  Contact lenses will include conventional or disposable.  This benefit can only be used one time per plan year. Any remaining benefit dollars do not "rollover" to a future purchase.	Any amount over <b>\$375</b>	Any amount over <b>\$375</b>	One per year

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 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 Myhumana.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.

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.

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## 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)**.



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