

Summary of Benefits

Optional Supplemental Benefits

Humana Gold Choice H2944-013 (PFFS)

Central

Select Counties in KS, MO and OK

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

- ☐ 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, 2023.
- ☐ 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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Our service area includes the following county/counties in Kansas: Chase, Cheyenne, Clark, Coffey, Edwards, Finney, Ford, Gove, Graham, Gray, Jewell, Kearny, Lane, Logan, Lyon, Meade, Mitchell, Morton, Ness, Norton, Osborne, Phillips, Rawlins, Riley, Rush, Saline, Smith, Stevens, Trego, Washington, Wichita

Missouri: Butler, Chariton, Clark, Dunklin, Macon, Schuyler, Sullivan

Oklahoma: Atoka, Beckham, Choctaw, Coal, Jackson, McCurtain.



Let's talk about Humana Gold Choice H2944-013 (PFFS)

Find out more about the Humana Gold Choice H2944-013 (PFFS) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Choice H2944-013 (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 H2944-013 (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 H2944-013 (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](https://www.humana.com/medicare)

More about Humana Gold Choice H2944-013 (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 H2944-013 (PFFS) may have a network for DME, Lab and/or Home Health. If you use providers who aren't in our network for DME, Lab and/or Home Health, you may be subject to higher copayment/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

\$41

You must keep paying your Medicare Part B premium.

If you receive premium assistance, your plan premium may be reduced.

Medical deductible

This plan does not have a deductible.

Pharmacy (Part D) deductible

\$195 for Tier 3, Tier 4, Tier 5

Maximum out-of-pocket responsibility

\$6,700 combined in- and out-of-network

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



Covered Medical and Hospital Benefits

IN-NETWORK

OUT-OF-NETWORK

ACUTE INPATIENT HOSPITAL CARE

\$295 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.

OUTPATIENT HOSPITAL COVERAGE

Outpatient surgery at outpatient hospital

30% of the cost

Outpatient surgery at ambulatory surgical center

25% of the cost

DOCTOR OFFICE VISITS

Primary care provider (PCP)

\$10 copay

Specialists

\$40 copay



Covered Medical and Hospital Benefits (cont.)

H2944013000

	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE	<p>Our plan covers many preventive services at no cost when you see an in-network provider including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • 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 	<p>\$0 copay Out of network benefits only apply to Freestanding Lab place of treatment</p> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>



Covered Medical and Hospital Benefits (cont.)

IN-NETWORK

OUT-OF-NETWORK

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

EMERGENCY CARE

Emergency room

\$90 copay

Urgently needed services

\$30 copay at an urgent care center

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

OUTPATIENT CARE AND DIAGNOSTIC SERVICES, LABS AND IMAGING

Cost share may vary depending on the service and where service is provided
Out of network benefits only apply to Freestanding Lab place of treatment

Diagnostic mammography

\$40 copay or **25%** to **30%** of the cost

Diagnostic radiology

\$180 to **\$270** copay

Lab services

\$0 to **\$30** copay or **30%** of the cost

\$0 copay

Diagnostic tests and procedures

\$0 to **\$45** copay or **30%** of the cost

Outpatient X-rays

\$10 to **\$40** copay or **25%** to **30%** of the cost

Radiation therapy

\$40 copay or **20%** of the cost

HEARING SERVICES

Medicare-covered hearing

\$40 copay

DENTAL SERVICES

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

Medicare-covered dental

\$40 copay

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

\$40 copay

Medicare-covered diabetic eye exam

\$0 copay



Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Medicare-covered glaucoma screening	\$0 copay	
Medicare-covered eyewear (post-cataract)	\$0 copay	
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	\$295 copay per day for days 1-5 \$0 copay per day for days 6-90	
Outpatient group and individual therapy visits Cost share may vary depending on where service is provided.	\$40 copay or 30% of the cost	
SKILLED NURSING FACILITY (SNF)		
Your plan covers up to 100 days in a SNF	\$0 copay per day for days 1-20 \$188 copay per day for days 21-100	
PHYSICAL THERAPY		
Cost share may vary depending on the service and where service is provided.	\$35 to \$40 copay	
AMBULANCE		
Ambulance (ground)	\$265 copay per date of service	
Ambulance (air)	20% of the cost	
TRANSPORTATION		
	Not covered	Not covered



Prescription Drug Benefits

MEDICARE PART B DRUGS		
Chemotherapy drugs	20% of the cost	
Other Part B drugs	20% of the cost	

PRESCRIPTION DRUGS

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

Deductible This plan has a **\$195** deductible for Tier 3, Tier 4, Tier 5 drugs. You pay the full cost of these drugs until you reach \$195. 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 **\$4,430**. 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 Humana.com/pharmacyfinder		Mail order Humana Pharmacy [®]	
	30-day supply	90-day supply	30-day supply	90-day supply
Tier 1: Preferred Generic	\$7	\$21	\$7	\$0
Tier 2: Generic	\$14	\$42	\$14	\$0
Tier 3: Preferred Brand	\$47	\$141	\$47	\$131
Tier 4: Non-Preferred Drug	\$99	\$297	\$99	\$287
Tier 5: Specialty Tier	29%	N/A	29%	N/A

Standard cost-sharing

Pharmacy options	Retail All other network retail pharmacies.		Mail order Walmart Mail, PillPack	
	30-day supply	90-day supply	30-day supply	90-day supply
Tier 1: Preferred Generic	\$10	\$30	\$10	\$30
Tier 2: Generic	\$20	\$60	\$20	\$60
Tier 3: Preferred Brand	\$47	\$141	\$47	\$141
Tier 4: Non-Preferred Drug	\$100	\$300	\$100	\$300
Tier 5: Specialty Tier	29%	N/A	29%	N/A

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

Other pharmacies are available in our network.

Specialty drugs are limited to a 30-day supply.

If you receive Extra Help for your drugs, you'll pay the following:

Deductible You may pay **\$0** or **\$99** depending on your level of Extra Help (for Tier 3, Tier 4, Tier 5). If your deductible is **\$99**, you pay the full cost of these drugs until you reach **\$99**. Then, you only pay your cost-share.

Pharmacy cost-sharing

	30-day supply	90-day supply
For generic drugs (including brand drugs treated as generic), either:	\$0 copay; or \$1.35 copay; or \$3.95 copay ; or 15% of the cost	\$0 copay; or \$1.35 copay; or \$3.95 copay ; or 15% of the cost
For all other drugs , either:	\$0 copay; or \$4 copay; or \$9.85 copay ; or 15% of the cost	\$0 copay; or \$4 copay; or \$9.85 copay ; or 15% of the cost

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 the additional pharmacy-specific cost-sharing and the phases of the 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 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 **25 percent** of the plan's cost for covered generic drugs until your costs total **\$7,050** — 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 **\$7,050**, you pay the greater of:

- **5%** of the cost, or
- **\$3.95** copay for generic (including brand drugs treated as generic) and a **\$9.85** copayment for all other drugs



Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
Medicare-covered foot care (podiatry)	\$40 copay	
Medicare-covered chiropractic services	\$10 copay	
MEDICAL EQUIPMENT/SUPPLIES		
Out of network benefits only apply to DME providers		
Durable medical equipment (like wheelchairs or oxygen)	14% of the cost	15% of the cost
Medical Supplies	20% of the cost	
Prosthetics (artificial limbs or braces)	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	20% of the cost
REHABILITATION SERVICES		
Occupational and speech therapy Cost share may vary depending on the service and where service is provided.	\$35 to \$40 copay	
Cardiac rehabilitation Cost share may vary depending on the service and where service is provided.	\$15 to \$30 copay	
Pulmonary rehabilitation	\$30 copay	
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	\$0 copay	Not Covered
Specialist	\$40 copay	Not Covered
Urgent care services	\$0 copay	Not Covered
Substance abuse or behavioral health services	\$0 copay	Not Covered



More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

COVID-19 Testing and Treatment

\$0 copay for testing and treatment services for COVID-19.

Humana Well Dine® Meal Program

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

Over-the-Counter (OTC) card

\$50 maximum benefit coverage amount per month for over-the-counter (OTC) card to purchase eligible OTC health and wellness products at participating retailers.

Rewards and Incentives

Go365 by Humana® a Rewards and Incentive program for completing certain preventive health screenings and health and wellness activities.



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.

\$20

MyOption Dental - High DEN838

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

\$22.20

MyOption Plus DEN843 & VIS759

Includes benefits for preventive and basic dental services at both in-network (HumanaDental Medicare network) and out-of-network dentists as well as vision benefits. These 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 benefits have an additional monthly premium.

\$15

MyOption Fitness

A basic fitness membership at any SilverSneakers® participating location in the country. Members have access to locations across the nation.

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



Find out **more**



You can see our plan's **provider and pharmacy directory** at our website at **humana.com/finder/search** or call us at the number listed at the beginning of this booklet and we will send you one.



You can see our plan's **drug guide** at our website at **humana.com/medicaredruglist** or call us at the number listed at the beginning of this booklet and we will send you one.

To find out more about the coverage and costs of Original Medicare, look in the current “Medicare & You” handbook. View it online at <http://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Telehealth services shown are in addition to the Original Medicare covered telehealth. Your cost may be different for Original Medicare telehealth.

Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services are for informational purposes only and should not be construed as medical advice. Please refer to your evidence of coverage for additional details on what your plan may cover or other rules that may apply.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

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Optional Supplemental Benefits

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Central
Select Counties in KS, MO and OK

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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.

MyOptionSM Dental – High (DEN838)

The MyOptionSM Dental – High benefit helps make it easy for you to plan for your dental care.

Here's how the benefit works:

Monthly Premium	\$20		
Maximum Benefit	Humana pays up to \$2,000 per calendar year		
Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations Per Calendar Year
Preventive and Diagnostic Dental Services			
Periodic oral examinations	0%	50%	Two per year
Emergency diagnostic exam	0%	50%	
Periodontal exam	0%	50%	One procedure every three years
Comprehensive oral evaluation	0%	50%	
Dental prophylaxis (cleanings)	0%	50%	Two per year
Fluoride treatment	0%	50%	Two per year
Bitewing X-ray	0%	50%	One set per year
Intraoral X-ray	0%	50%	One per year
Panoramic or diagnostic X-ray	0%	50%	One procedure every three years
Periodontal Maintenance	0%	50%	Four procedures per calendar year
Basic Dental Services (Minor Restorative)			
Amalgam restorations (silver fillings)	50%	55%	Two per year
Composite resin restorations (white fillings)	50%	55%	

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations Per Calendar Year
Basic Dental Services (Minor Restorative)			
Extractions (pulling teeth), simple or surgical	50%	55%	Two per year
Recementation – Crown	50%	55%	One procedure every five years
Emergency treatment for pain	50%	55%	Two per year
Anesthesia	0%	50%	Unlimited procedures per year
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Crowns	70%	75%	Two per year
Periodontal scaling and root planing (deep cleaning)	70%	75%	One procedure for each quadrant every three years
Scaling – generalized inflammation	70%	75%	One procedure every three years

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 a negotiated rate. If you see a network dentist, you can't be billed more than that rate.

**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.

Some covered services may consider prior tooth history and procedures in conjunction with frequency limitations noted above. 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**.

MyOptionSM Plus (DEN843 & VIS759)

MyOptionSM Plus helps make it easy to plan for both your dental and vision care.

Here's how the benefit works:

Monthly Premium	\$22.20
Annual Deductible	Dental: \$50 for basic services per calendar year Vision: There is no annual deductible

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Maximum Benefit	Dental: Humana pays up to \$1,000 per calendar year Vision: Humana pays up to \$290 for one pair of eyeglass frames and one pair of lenses OR contact lenses (includes conventional or disposable)		
Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations Per Calendar Year
Preventive and Diagnostic Dental Services			
Oral examinations	0%	30%	Two per year
Dental prophylaxis (cleanings)	0%	30%	Two per year
Fluoride treatment	0%	30%	Two procedures per year
Bitewing X-ray	0%	30%	One set per year
Periodontal maintenance	0%	30%	Four procedures per year
Anesthesia - Nitrous	0%	30%	Unlimited per year
Basic Dental Services (Minor Restorative)			
Amalgam restorations (silver fillings)	50%	55%	Two per year
Composite resin restorations (white fillings)	50%	55%	
Extractions (pulling teeth), simple or surgical	50%	55%	Two per year
Recementation – Crown or Bridge	50%	55%	One per year
Emergency treatment for pain	50%	55%	Two per 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

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Vision Benefits	In-Network You Pay	Out-Of-Network*** You Pay	Benefit Limitations
<p>\$290 (combined in and out-of-network) benefit toward the purchase and fitting of eyeglasses and pair of lenses or contact lenses.</p> <p>Eyeglass lens options may be available with the maximum benefit. Coverage amount is limited to one time use per year.</p> <p>Contact lenses will include conventional or disposable.</p> <p>The benefit can only be used one time per plan year. Any remaining benefit dollars do not "roll over" to a future purchase.</p>	Any amount over \$290 retail price	Any amount over \$290 retail price	One per year

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

Covered dental and vision 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 a negotiated rate. If you see a network dentist, you cannot be billed more than that rate.

**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.

Some covered services may consider prior tooth history and procedures in conjunction with frequency limitations noted above. 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**.

***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.

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

The provider locator for routine vision can be found at [Humana.com](https://www.humana.com) > **Find a Doctor** > select **Vision care icon** > **Vision coverage through Medicare Advantage plans.**

MyOptionSM Vision (VIS757)

The MyOptionSM 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 \$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

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

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.**

MyOptionSM Fitness

The MyOptionSM Fitness benefit helps you pay for your fitness needs. This benefit covers the cost of a basic membership at any SilverSneakers[®] fitness center anywhere in the country.

You can reach your health, wellness, and fitness goals with SilverSneakers classes. The monthly premium for this OSB is **\$15**. Here's how the benefit works:

Covered services

- Fitness center membership at any participating SilverSneakers fitness center.
- Tools for tracking your physical activity.

Fitness Center memberships

- Use of exercise equipment, pool, and sauna where available. Not every fitness center has all of these options.
- Attend SilverSneakers classes designed to help improve your strength, flexibility, balance, and endurance.
- Attend events to help you work towards being healthy.
- Find online support that can help you lose weight or start an exercise program.
- Meet with a trained Program Advisor[™] at the fitness center to help you get started.
- Any nonstandard fitness center services that usually have an extra fee are not included in your membership.

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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, marital status or religion. 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.

Language assistance services, free of charge, are available to you.

1-877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Diné Bizaad (Navajo): Wóda'í béésh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'déé nika'adoowoł.

العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

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Select Counties in KS, MO and OK

