2022

Summary of Benefits

Optional Supplemental Benefits

HumanaChoice H5525-027 (PPO)

Western Montana
Select Counties in Montana

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 Montana: Beaverhead, Broadwater, Chouteau, Deer Lodge, Fergus, Granite, Jefferson, Judith Basin, Lake, Lewis and Clark, Liberty, Lincoln, Madison, Meagher, Mineral, Missoula, Pondera, Powell, Sanders, Silver Bow, Teton.

Let's talk about HumanaChoice H5525-027 (PPO)

Find out more about the HumanaChoice H5525-027 (PPO) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice H5525-027 (PPO) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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

To be eligible

To join HumanaChoice H5525-027 (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

HumanaChoice H5525-027 (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 H5525-027 (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 H5525-027 (PPO) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, you may be subject to higher copayments/coinsurance.

A healthy partnership

Get more from your plan — with extra services and resources provided by Humana!

Monthly Premium, Deductible and Limits

PLAN COSTS	
Monthly plan premium You must keep paying your Medicare Part B premium.	**$64** If you receive premium assistance, your plan premium may be reduced.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	**$350** for Tier 4, Tier 5
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for medical services for the year.	**$5,500** in-network **$10,000** combined in- and out-of-network

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
	$360 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.	**50%** of the cost
OUTPATIENT HOSPITAL COVERAGE		
Outpatient surgery at outpatient hospital	**$250** copay	**50%** of the cost
Outpatient surgery at ambulatory surgical center	**$200** copay	**50%** of the cost
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$15** copay	**50%** of the cost
Specialists	**$40** copay	**50%** of the cost

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE		
	Our plan covers many preventive services at no cost when you see an in-network provider including: • 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	**$0** copay or **50%** of the cost, depending on the service and where service is provided Any additional preventive services approved by Medicare during the contract year will be covered.

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
	Any additional preventive services approved by Medicare during the contract year will be covered.	
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.	**$25** copay at an urgent care center	**50%** 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	**$35** to **$80** copay	**50%** of the cost
Diagnostic radiology	**$180** to **$250** copay	**50%** of the cost
Lab services	**$0** to **$40** copay	**50%** of the cost
Diagnostic tests and procedures	**$0** to **$90** copay	**50%** of the cost
Outpatient X-rays	**$15** to **$90** copay	**50%** of the cost
Radiation therapy	**20%** of the cost	**50%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**$40** copay	**50%** of the cost
DENTAL SERVICES The cost-share indicated below is what you pay for the covered service. Additional dental benefits are available with a separate monthly premium. Please see the "Optional Supplemental Benefits" page for details.		
Medicare-covered dental	**$40** copay	**50%** of the cost
Routine dental Dental benefits may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**.	**DEN351** • **0%** coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **0%** coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years.	**DEN351** • **0%** coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **0%** coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years.

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Use the HumanaDental Medicare network for the Mandatory Supplemental Dental. The provider locator can be found at **Humana.com** > Find a Doctor > from the Search Type drop down select Dental > under Coverage Type select All Dental Networks > enter zip code > from the network drop down select HumanaDental Medicare.	• **0%** coinsurance for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • **0%** coinsurance for emergency diagnostic exam up to 1 per year. • **0%** coinsurance for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **0%** coinsurance for periodontal maintenance up to 4 per year. • **0%** coinsurance for necessary anesthesia with covered service up to unlimited per year. • **$25** copayment for amalgam and/or composite filling up to 2 per year. • **$1000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits.	• **0%** coinsurance for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • **0%** coinsurance for emergency diagnostic exam up to 1 per year. • **0%** coinsurance for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **0%** coinsurance for periodontal maintenance up to 4 per year. • **0%** coinsurance for necessary anesthesia with covered service up to unlimited per year. • **$25** copayment for amalgam and/or composite filling up to 2 per year. • **$1000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
VISION SERVICES 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	**50%** of the cost
Medicare-covered diabetic eye exam	**$0** copay	**50%** of the cost
Medicare-covered glaucoma screening	**$0** copay	**50%** of the cost
Medicare-covered eyewear (post-cataract)	**$0** copay	**50%** of the cost

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$318** copay per day for days 1-5 **$0** copay per day for days 6-90	**50%** of the cost
Outpatient group and individual therapy visits Cost share may vary depending on where service is provided.	**$40** to **$90** copay	**50%** 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 21-50 **$0** copay per day for days 51-100	**50%** of the cost for days 1-100
PHYSICAL THERAPY		
	$40 copay	**50%** of the cost
AMBULANCE		
Ambulance (ground)	**$290** copay per date of service	**$290** copay per date of service
Ambulance (air)	**20%** of the cost	**20%** of the cost
TRANSPORTATION		
	Not covered	Not covered

Prescription Drug Benefits

MEDICARE PART B DRUGS		
Chemotherapy drugs	**20%** of the cost	**50%** of the cost
Other Part B drugs	**20%** of the cost	**50%** of the cost

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

PRESCRIPTION DRUGS

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

Deductible This plan has a **$350** deductible for Tier 4, Tier 5 drugs. You pay the full cost of these drugs until you reach $350. Then, you only pay your cost-share. There is no deductible for Select Insulins as part of the Insulin Savings Program. During this stage, you will pay no more than $35 for a one-month (up to a 30-day) supply for Select Insulins. See the Additional Drug Coverage section of this document for additional details.

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. As part of the Insulin Savings Program, you will pay no more than $35 for a one-month (up to a 30-day) supply for Select Insulins in the initial coverage stage. See the Additional Drug Coverage section of this document for specific details.

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	$2	$6	$2	$0
Tier 2: Generic	$15	$45	$15	$0
Tier 3: Preferred Brand	$47	$141	$47	$131
Tier 4: Non-Preferred Drug	$100	$300	$100	$290
Tier 5: Specialty Tier	27%	N/A	27%	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	27%	N/A	27%	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 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		
For generic drugs (including brand drugs treated as generic), either:	**30-day supply**	**90-day supply**
	$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

ADDITIONAL DRUG COVERAGE

This plan participates in the Insulin Savings Program which provides affordable, predictable copayments on Select Insulins through the first three drug payment stages (Deductible (if applicable), Initial Coverage and Coverage Gap) of the Part D benefit. The Insulin Savings Program does not apply to the Catastrophic Coverage stage. To find out which drugs are Select Insulins, please check this plan's Humana Drug Guide. You can identify Select Insulins by the "**ISP**" indicator in the Drug Guide. You are not eligible for this program if you receive Extra Help.

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

Preferred cost-sharing for Select Insulins				
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 3: Preferred Brand	**$35**	**$105**	**$35**	**$95**
Standard cost-sharing for Select Insulins				
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 3: Preferred Brand	**$35**	**$105**	**$35**	**$105**

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. As part of the Insulin Savings Program, you will pay no more than $35 for a one-month (up to a 30-day) supply for Select Insulins in the coverage gap. See the Additional Drug Coverage section of this document for specific details. Not everyone will enter the coverage gap.

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

Tier 3 (Preferred Brand) - Select Insulin Drugs

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

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	**50%** of the cost
Medicare-covered chiropractic services	**$20** copay	**50%** of the cost
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**18%** of the cost	**20%** of the cost
Medical Supplies	**20%** of the cost	**50%** of the cost
Prosthetics (artificial limbs or braces)	**20%** of the cost	**50%** 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	**50%** of the cost
REHABILITATION SERVICES		
Occupational and speech therapy	**$40** copay	**50%** of the cost
Cardiac rehabilitation	**$30** copay	**50%** of the cost
Pulmonary rehabilitation	**$30** copay	**50%** of the cost
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered
Specialist	**$40** copay	Not Covered
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

COVID-19 Testing and Treatment

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

Travel Coverage

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

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) mail order

$50 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products.

Rewards and Incentives

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

SilverSneakers® fitness program

Basic fitness center membership including fitness classes.

Optional **Supplemental Benefits**

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

$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.

$62.30

MyOption DEN204

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

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

Find out **more**

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

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

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

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

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

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

Out-of-network/non-contracted providers are under no obligation to treat Humana members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Humana®

Humana.com

2022

Optional Supplemental Benefits

HumanaChoice H5525-027 (PPO)

Western Montana
Select Counties in Montana

Humana®

My Options, My Choice
Adding Benefits to Your Plan

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

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

MyOption℠ Vision (VIS757)

The MyOption℠ 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

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Vision Benefits	In-Network You Pay	Out-Of-Network* You Pay	Benefit Limitations
$375 (combined in and out-of-network) benefit toward the purchase and fitting of eyeglasses and pair of lenses or contact lenses. Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year. Contact lenses will include conventional or disposable. This benefit can only be used one time per plan year. Any remaining benefit dollars do not "roll over" to a future purchase.	Any amount over **$375** retail price	Any amount over **$375** retail price	One per year

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

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

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

The provider locator for routine vision can be found at **Humana.com > Find a Doctor > select Vision care icon > Vision coverage through Medicare Advantage plans.**

MyOption℠ (DEN204)

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

This benefit has no deductible.

Here's how the benefit works:

Monthly Premium	**$62.30**

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

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

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

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

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

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

*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.**

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

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Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, 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): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę́ niká'adoowoł.

العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

HumanaChoice H5525-027 (PPO)

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