

# Summary of Benefits

## Optional Supplemental Benefits

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### **Humana Gold Plus H6622-002 (HMO)**

Milwaukee  
Milwaukee area

Our service area includes the following county/counties in Wisconsin: Dane, Kenosha, Milwaukee, Ozaukee, Racine, Rock, Sheboygan, Walworth, Washington, Waukesha.

**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, 2023.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

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# Let's talk about Humana Gold Plus H6622-002 (HMO)

Find out more about the Humana Gold Plus H6622-002 (HMO) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus H6622-002 (HMO) is a Medicare Advantage HMO 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 Plus H6622-002 (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

## Plan name:

Humana Gold Plus H6622-002 (HMO)

## How to reach us:

If you're a member of this plan, call toll-free: **1-800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-833-2364 (TTY: 711)**.

## October 1 - March 31:

Call 7 days a week from 8 a.m. - 8 p.m.

## April 1 - September 30:

Call Monday - Friday, 8 a.m. - 8 p.m.

Or visit our website:

**Humana.com/medicare**

## More about Humana Gold Plus H6622-002 (HMO)

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 you must select an in-network doctor to act as your Primary Care Provider (PCP). Humana Gold Plus H6622-002 (HMO) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services.



## A healthy partnership

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



## Monthly Premium, Deductible and Limits

|   |   |
|---|---|
| <b>Monthly Plan Premium</b>                 | <b>\$26</b><br>You must keep paying your Medicare Part B premium.<br>If you receive premium assistance, your plan premium may be reduced. |
| <b>Medical deductible</b>                   | This plan does not have a deductible.   |
| <b>Pharmacy (Part D) deductible</b>         | <b>\$200</b> for Tier 4, Tier 5   |
| <b>Maximum out-of-pocket responsibility</b> | <b>\$4,000</b> in-network<br>The most you pay for copays, coinsurance and other costs for medical services for the year.                  |



## Covered Medical and Hospital Benefits

|                                      |   |
|--------------------------------------|---|
| <b>Acute inpatient hospital care</b> | <b>\$250</b> copay per day for days 1-6<br><b>\$0</b> copay per day for days 7-90<br>Your plan covers an unlimited number of days for an inpatient stay.  |
| <b>Outpatient hospital coverage</b>  | <ul style="list-style-type: none"> <li>• Outpatient surgery at Outpatient Hospital: <b>\$250</b> copay</li> <li>• Outpatient surgery at Ambulatory Surgical Center: <b>\$200</b> copay</li> </ul> |
| <b>Doctor visits</b>                 | <ul style="list-style-type: none"> <li>• Primary care provider: <b>\$0</b> copay</li> <li>• Specialist: <b>\$40</b> copay</li> </ul>  |

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.)

### 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

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

### EMERGENCY CARE

#### Emergency room

**\$90** copay

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.

#### Urgently needed services

**\$25** 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 SERVICES

#### Diagnostic services, labs and imaging

Cost share may vary depending on the service and where service is provided

- Diagnostic mammography: **\$35 to \$80** copay
- Diagnostic radiology: **\$0 to \$250** copay
- Lab services: **\$0 to \$35** copay
- Diagnostic tests and procedures: **\$0 to \$85** copay
- Outpatient X-rays: **\$0 to \$90** copay
- Radiation therapy: **20%** of the cost

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## Covered Medical and Hospital Benefits (cont.)

H6622002000

### Hearing

Medicare-covered hearing exam: **\$40** copay

#### Routine hearing:

In-Network:

#### **HER937**

- **\$0** copayment for routine hearing exams up to 1 per year.
- **\$699** copayment for each Advanced level hearing aid up to 1 per ear per year.
- **\$999** copayment for each Premium level hearing aid up to 1 per ear per year.

Hearing aid purchase includes:

- Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase
- 60-day trial period
- 3-year extended warranty
- 80 batteries per aid for non-rechargeable models

**You must see a TruHearing provider to use this benefit. Call**

**1-844-255-7144 to schedule an appointment (for TTY, dial 711).**

### Dental

Medicare-covered dental services: **\$40** copay

#### Routine dental:

The cost-share indicated below is what you pay for the covered service.

In-Network:

#### **DEN311**

- **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.
- **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** maximum benefit coverage amount per year for preventive and comprehensive benefits.

Dental benefits may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**.

Use the HumanaDental Medicare network for the Mandatory Supplemental Dental. The provider locator can be found at

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## Covered Medical and Hospital Benefits (cont.)

**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.

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

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### Vision

- Medicare-covered vision services: **\$40** copay
- Medicare-covered diabetic eye exam: **\$0** copay
- Medicare-covered glaucoma screening: **\$0** copay
- Medicare-covered eyewear (post-cataract): **\$0** copay

#### Routine vision:

In-Network:

#### **VIS735**

- **\$0** copayment for routine exam up to 1 per year.
- **\$200** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.
- 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.

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

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.

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### Mental health services

#### Inpatient:

- **\$250** copay per day for days 1-6
- **\$0** copay per day for days 7-90
- Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.

**Outpatient** (group and individual therapy visits): **\$40** to **\$90** copay  
Cost share may vary depending on where service is provided.

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### Skilled nursing facility (SNF)

- **\$0** copay per day for days 1-20
- **\$188** copay per day for days 21-100
- Your plan covers up to 100 days in a SNF

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### Physical Therapy

- **\$40** copay

### ADDITIONAL BENEFITS

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#### Ambulance (ground)

**\$290** copay per date of service

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#### Ambulance (air)

**20%** 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.)

### Transportation

**\$0** copay for plan approved location up to 24 one-way trip(s) per year. This benefit is not to exceed 100 miles per trip.

The member *must* contact transportation vendor to arrange transportation.



## 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 **\$200** deductible for Tier 4, Tier 5 drugs. You pay the full cost of these drugs until you reach \$200. 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        |               | Mail order    |               |
|-----------------------------------|---------------|---------------|---------------|---------------|
|                                   | 30-day supply | 90-day supply | 30-day supply | 90-day supply |
| <b>Tier 1:</b> Preferred Generic  | \$6           | \$18          | \$6           | \$0           |
| <b>Tier 2:</b> Generic            | \$15          | \$45          | \$15          | \$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     | 29%           | N/A           | 29%           | N/A           |

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.

**Standard cost-sharing**

| Pharmacy options           | Retail        |               | Mail order    |               |
|----------------------------|---------------|---------------|---------------|---------------|
|                            | 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 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   |
|--|---|---|
| <b>For generic drugs</b> (including brand drugs treated as generic), either: | <b>\$0</b> copay; or<br><b>\$1.35</b> copay; or<br><b>\$3.95</b> copay ; or<br><b>15%</b> of the cost | <b>\$0</b> copay; or<br><b>\$1.35</b> copay; or<br><b>\$3.95</b> copay ; or<br><b>15%</b> of the cost |
| <b>For all other drugs</b> , either:   | <b>\$0</b> copay; or<br><b>\$4</b> copay; or<br><b>\$9.85</b> copay ; or<br><b>15%</b> of the cost    | <b>\$0</b> copay; or<br><b>\$4</b> copay; or<br><b>\$9.85</b> copay ; or<br><b>15%</b> 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 <a href="https://www.humana.com/pharmacyfinder">Humana.com/pharmacyfinder</a> |               | 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

**Medicare-covered foot care (podiatry)**      **\$40** copay

**Medicare-covered chiropractic services**      **\$20** copay

**Medical equipment/ supplies**

Cost share may vary depending on the service and where service is provided

- Durable medical equipment (like wheelchairs or oxygen): **20%** of the cost
- Medical supplies: **20%** of the cost
- Prosthetics (artificial limbs or braces): **20%** of the cost
- Diabetic monitoring supplies: **\$0** copay or **10%** to **20%** of the cost

**Rehabilitation services**

- Occupational and speech therapy: **\$40** copay
- Cardiac rehabilitation: **\$0** copay
- Pulmonary rehabilitation: **\$0** copay

**Telehealth services (in addition to Original Medicare)**

- Primary care provider (PCP): **\$0** copay
- Specialist: **\$40** copay
- Urgent care services: **\$0** copay
- Substance abuse and behavioral health services: **\$0** copay



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# More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

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## **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) 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.

**\$77.10**

### **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.

**\$109.70**

### **MyOption DEN205**

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**

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You can see our plan's **provider and pharmacy directory** at our website at **[humana.com/finder/search](http://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](http://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.

Medicare-covered eye refractions during a specialist medical visit are not covered.

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.



2022

# Optional Supplemental Benefits

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## **Humana Gold Plus H6622-002 (HMO)**

Milwaukee  
Milwaukee area

**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.

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<sup>SM</sup> (DEN204)

The MyOption<sup>SM</sup> 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:

|   |  |                                     |  |
|---|--|-------------------------------------|--|
| <b>Monthly Premium</b>  | <b>\$77.10</b>                                     |                                     |  |
| <b>Maximum Benefit</b>  | Humana pays up to <b>\$2,000</b> per calendar year |                                     |  |
| <b>Covered Dental Services</b>                                | <b>In-Network*<br/>You Pay</b>                     | <b>Out-Of-Network**<br/>You Pay</b> | <b>Benefit Limitations Per<br/>Calendar Year</b> |
| <b>Basic Dental Services (Minor Restorative)</b>              |  |                                     |  |
| Amalgam restoration (silver fillings)                         | <b>\$25</b>  | <b>\$25</b>                         | Unlimited per year                               |
| Composite resin restoration (white fillings)                  | <b>\$25</b>  | <b>\$25</b>                         |  |
| Extraction, erupted tooth or exposed root                     | <b>\$25</b>  | <b>\$25</b>                         | Unlimited procedures per year                    |
| Surgical removal of erupted tooth                             | <b>\$25</b>  | <b>\$25</b>                         |  |
| Recement inlay, onlay or partial coverage restoration         | <b>\$25</b>  | <b>\$25</b>                         | One procedure every five years                   |
| Recement indirectly fabricated or prefabricated post and core | <b>\$25</b>  | <b>\$25</b>                         |  |
| Recement crown  | <b>\$25</b>  | <b>\$25</b>                         |  |
| Palliative (emergency) treatment of dental pain               | <b>\$25</b>  | <b>\$25</b>                         | Two procedures per year                          |

**OPTIONAL SUPPLEMENTAL BENEFITS** (continued)

| <b>Covered Dental Services</b>  | <b>In-Network*<br/>You Pay</b> | <b>Out-Of-<br/>Network**<br/>You Pay</b> | <b>Benefit Limitations Per<br/>Calendar Year</b>         |
|---|--------------------------------|--|--|
| <b>Basic Dental Services (Minor Restorative)</b>  |                                |  |  |
| Anesthesia  | <b>0%</b>                      | <b>0%</b>                                | Unlimited procedures per year                            |
| <b>Major Dental Services (Endodontics, Periodontics, and Oral Surgery)</b>  |                                |  |  |
| Periodontal scaling and root planing  | <b>\$25</b>                    | <b>\$25</b>                              | One procedure for each quadrant every three years        |
| Scaling – moderate or severe gingival inflammation  | <b>\$25</b>                    | <b>\$25</b>                              | One procedure every three years                          |
| Crowns  | <b>50%</b>                     | <b>50%</b>                               | One procedure code per tooth per lifetime                |
| Onlay   | <b>50%</b>                     | <b>50%</b>                               |  |
| Inlay – alternate benefit only  | <b>50%</b>                     | <b>50%</b>                               |  |
| Complete denture (including routine post-delivery care) – maxillary (upper) or mandibular (lower)                 | <b>50%</b>                     | <b>50%</b>                               | One upper and/or lower complete denture every five years |
| Immediate denture (including routine post-delivery care) – maxillary (upper) or mandibular (lower)                | <b>50%</b>                     | <b>50%</b>                               |  |
| Partial dentures (including routine post-delivery care) – resin or metal, maxillary (upper) or mandibular (lower) | <b>50%</b>                     | <b>50%</b>                               | One upper and/or lower partial denture every five years  |
| Unilateral partial denture (including routine post-delivery care)   | <b>50%</b>                     | <b>50%</b>                               |  |
| Complete denture adjustment – maxillary (upper) or mandibular (lower)   | <b>50%</b>                     | <b>50%</b>                               | One procedure per year                                   |
| Partial denture adjustment – maxillary (upper) or mandibular (lower)  | <b>50%</b>                     | <b>50%</b>                               |  |
| Reline complete denture – maxillary (upper) or mandibular (lower)   | <b>50%</b>                     | <b>50%</b>                               | One procedure per year                                   |
| Reline partial denture – maxillary (upper) or mandibular (lower)  | <b>50%</b>                     | <b>50%</b>                               |  |

**OPTIONAL SUPPLEMENTAL BENEFITS** (continued)

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

\*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](http://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](http://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**.

**OPTIONAL SUPPLEMENTAL BENEFITS** (continued)

**MyOption<sup>SM</sup> (DEN205)**

The MyOption<sup>SM</sup> 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:

|  |  |                                     |   |
|--|--|-------------------------------------|---|
| <b>Monthly Premium</b>   | <b>\$109.70</b>                                    |                                     |   |
| <b>Maximum Benefit</b>   | Humana pays up to <b>\$2,000</b> per calendar year |                                     |   |
| <b>Covered Dental Services</b>   | <b>In-Network*<br/>You Pay</b>                     | <b>Out-Of-Network**<br/>You Pay</b> | <b>Benefit Limitations Per<br/>Calendar Year</b>  |
| <b>Basic Dental Services (Minor Restorative)</b>                           |  |                                     |   |
| Amalgam restoration (silver fillings)                                      | <b>0%</b>  | <b>0%</b>                           | Unlimited procedures per year                     |
| Composite resin restoration (white fillings)                               | <b>0%</b>  | <b>0%</b>                           |   |
| Extraction, erupted tooth or exposed root                                  | <b>0%</b>  | <b>0%</b>                           | Unlimited procedures per year                     |
| Surgical removal of erupted tooth  | <b>0%</b>  | <b>0%</b>                           |   |
| Recement inlay, onlay or partial coverage restoration                      | <b>\$25</b>  | <b>\$25</b>                         | One procedure every five years                    |
| Recement indirectly fabricated or prefabricated post and core              | <b>\$25</b>  | <b>\$25</b>                         |   |
| Recement crown   | <b>\$25</b>  | <b>\$25</b>                         |   |
| Recement fixed partial denture (bridge)                                    | <b>\$25</b>  | <b>\$25</b>                         | One procedure every five years                    |
| Palliative (emergency) treatment of dental pain                            | <b>\$25</b>  | <b>\$25</b>                         | Two procedures per year                           |
| Anesthesia   | <b>0%</b>  | <b>0%</b>                           | Unlimited procedures per year                     |
| <b>Major Dental Services (Endodontics, Periodontics, and Oral Surgery)</b> |  |                                     |   |
| Periodontal scaling and root planing                                       | <b>0%</b>  | <b>0%</b>                           | One procedure for each quadrant every three years |
| Scaling – moderate or severe gingival inflammation                         | <b>0%</b>  | <b>0%</b>                           | One procedure every three years                   |

**OPTIONAL SUPPLEMENTAL BENEFITS** (continued)

| <b>Covered Dental Services</b>  | <b>In-Network*<br/>You Pay</b> | <b>Out-Of-<br/>Network**<br/>You Pay</b> | <b>Benefit Limitations Per<br/>Calendar Year</b>                |
|---|--------------------------------|--|---|
| <b>Major Dental Services (Endodontics, Periodontics, and Oral Surgery)</b>  |                                |  |   |
| Root canal  | <b>50%</b>                     | <b>50%</b>                               | One procedure per tooth per lifetime                            |
| Root canal retreatment  | <b>50%</b>                     | <b>50%</b>                               | One procedure per tooth per lifetime                            |
| Crowns  | <b>50%</b>                     | <b>50%</b>                               | One procedure per tooth per lifetime                            |
| Onlay   | <b>50%</b>                     | <b>50%</b>                               |   |
| Inlay – alternate benefit only  | <b>50%</b>                     | <b>50%</b>                               |   |
| Pontic and retainer crown   | <b>50%</b>                     | <b>50%</b>                               | One procedure every five years                                  |
| Complete denture (including routine post-delivery care) – maxillary (upper) or mandibular (lower)                 | <b>50%</b>                     | <b>50%</b>                               | One upper and/or lower complete denture every five years        |
| Immediate denture (including routine post-delivery care) – maxillary (upper) or mandibular (lower)                | <b>50%</b>                     | <b>50%</b>                               |   |
| Partial dentures (including routine post-delivery care) – resin or metal, maxillary (upper) or mandibular (lower) | <b>50%</b>                     | <b>50%</b>                               | One upper partial and/or lower partial denture every five years |
| Unilateral partial denture (including routine post-delivery care)   | <b>50%</b>                     | <b>50%</b>                               |   |
| Complete denture adjustment – maxillary (upper) or mandibular (lower)   | <b>50%</b>                     | <b>50%</b>                               | One procedure per year  |
| Partial denture adjustment – maxillary (upper) or mandibular (lower)  | <b>50%</b>                     | <b>50%</b>                               |   |
| Reline complete denture – maxillary (upper) or mandibular (lower)   | <b>50%</b>                     | <b>50%</b>                               | One procedure per year  |
| Reline partial denture – maxillary (upper) or mandibular (lower)  | <b>50%</b>                     | <b>50%</b>                               |   |

**OPTIONAL SUPPLEMENTAL BENEFITS** (continued)

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

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**OPTIONAL SUPPLEMENTAL BENEFITS** (continued)

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

**Humana**<sup>®</sup>

[Humana.com](https://www.humana.com)

# 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 jii'eh saad bee áká'ánída'áwo'déé nika'adoowoł.

**العربية (Arabic)**

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك



Humana Gold Plus H6622-002 (HMO)

H6622002000 ENG

Milwaukee area



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