2023

Summary of Benefits

Optional Supplemental Benefits

Humana Gold Plus H5619-041 (HMO)

Charlottesville

Our service area includes the following county/counties in Virginia: Albemarle, Charlottesville City.

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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

- [ ] The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. 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.
- [ ] Review the formulary to make sure your drugs are covered.

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, 2024.
- [ ] 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).

Great news—Part B Insulin and Part B drug benefits on Humana's Medicare Advantage plans are getting even better in 2023.

At Humana, we strive to help our members achieve total health so that they may live their best lives, which includes efforts to provide our members with access to more affordable prescription drugs.

With the passing of the Inflation Reduction Act, all Medicare Advantage plans will have enhanced benefits in 2023:

Effective April 1, 2023, some rebatable Part B drugs may be subject to a lower coinsurance. This means beginning April 1, 2023, some Part B drugs will have a lower coinsurance than your standard part B drug coinsurance to help avoid increased cost for your Part B drugs. Any coinsurance adjustments will be made by the pharmacy at the time of purchase. Note, this does not impact your Part D prescription drug coverage.

Effective July 1, 2023, cost sharing for covered Part B Insulin furnished through a covered item of durable medical equipment will be no more than $35 for a one-month (up to 30-day) supply and if your plan has a deductible, it does not apply to Part B Insulin. Part B Insulin is most commonly used through an insulin pump.

Note, plan information provided in your previous member materials may not reflect these 2023 benefit enhancements from the passing of the Inflation Reduction Act.

2023

Summary of Benefits

Humana Gold Plus H5619-041 (HMO)

Charlottesville

Our service area includes the following county/counties in Virginia: Albemarle, Charlottesville City.

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Let's talk about Humana Gold Plus H5619-041 (HMO)

Find out more about the Humana Gold Plus H5619-041 (HMO) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus H5619-041 (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 H5619-041 (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 H5619-041 (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 H5619-041 (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 H5619-041 (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

Monthly Plan Premium	**$38** 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	This plan does not have a deductible.
Maximum out-of-pocket responsibility	**$6,700** in-network The most you pay for copays, coinsurance and other costs for covered medical services for the year.

Covered Medical and Hospital Benefits

Acute inpatient hospital care	**$345** 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: **$345** copay • Outpatient surgery at Ambulatory Surgical Center: **$295** copay
Doctor visits	• Primary care provider: **$10** copay • Specialist: **$45** copay

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.

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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	**$95** 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	**$35** 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.

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.)

OUTPATIENT CARE AND SERVICES

Diagnostic services, labs and imaging Cost share may vary depending on the service and where service is provided	• Diagnostic mammography: **$45** to **$75** copay • Diagnostic radiology: **$180** to **$295** copay • Lab services: **$0** to **$50** copay • Diagnostic tests and procedures: **$0** to **$95** copay • Outpatient X-rays: **$10** to **$105** copay • Radiation therapy: **$45** copay or **20%** of the cost
Hearing	Medicare-covered hearing exam: **$45** copay **Routine hearing:** In-Network: **HER937** • **$0** copay for routine hearing exams up to 1 per year. • **$699** copay for each Advanced level hearing aid up to 1 per ear per year. • **$999** copay 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: **$45** copay Additional dental benefits are available with a separate monthly premium. Please see the "Optional Supplemental Benefits" page for details.
Vision	• Medicare-covered vision services: **$45** copay • Medicare-covered diabetic eye exam: **$0** copay • Medicare-covered glaucoma screening: **$0** copay • Medicare-covered eyewear (post-cataract): **$0** copay Additional vision benefits are available with a separate monthly premium. Please see the "Optional Supplemental Benefits" page for details.

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.

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Covered Medical and Hospital Benefits (cont.)

Mental health services	**Inpatient:** • **$345** copay per day for days 1-4 • **$0** copay per day for days 5-90 • 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 **$95** copay Cost share may vary depending on where service is provided.
Skilled nursing facility (SNF)	• **$0** copay per day for days 1-20 • **$196** copay per day for days 21-55 • **$0** copay per day for days 56-100 • Your plan covers up to 100 days in a SNF
Physical Therapy Cost share may vary depending on the service and where service is provided.	• **$10** to **$40** copay
ADDITIONAL BENEFITS	
Ambulance	**$300** copay per date of service
Transportation	Not covered
Medicare Part B drugs	• Chemotherapy drugs: **20%** of the cost • Other Part B drugs: **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.

Prescription Drug Benefits

PRESCRIPTION DRUGS

Important Message About What You Pay for Vaccines
Our plan covers most Part D vaccines at no cost to you, no matter what cost-sharing tier it's on.

Important Message About What You Pay for Insulin
You won't pay more than $35 for a one-month (up to 30-day) supply of each Part D insulin product covered by our plan, no matter what cost-sharing tier it's on. This applies to all Part D covered insulins, including the Select Insulins covered under the Insulin Savings Program as described below. If you receive "Extra Help", you will still pay no more than $35 for a one-month supply for each Part D covered insulin. Please see your Prescription Drug Guide to find all Part D insulins covered by your plan.

If you don't receive Extra Help for your drugs, you'll pay the following:
Deductible This plan does not have a deductible.

Initial coverage
You pay the following until your total yearly drug costs reach **$4,660**. 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.

Mail Order Cost-Sharing

Pharmacy options	**Standard** Walmart Mail, PillPack Other pharmacies are available in our network. To find pharmacy mail order options go to **Humana.com/pharmacyfinder**		**Preferred** CenterWell Pharmacy™	
	30-day supply	**90-day supply***	**30-day supply**	**90-day supply***
Tier 1: Preferred Generic	$10	$30	$0	$0
Tier 2: Generic	$20	$60	$0	$0
Tier 3: Preferred Brand	$47	$141	$45	$125
Tier 4: Non-Preferred Drug	$100	$300	$95	$275
Tier 5: Specialty Tier	33%	N/A	33%	N/A

Retail Cost-Sharing		
Pharmacy options	**Retail** All network retail pharmacies. To find the retail pharmacies near you, go to **Humana.com/pharmacyfinder**	
	30-day supply	**90-day supply***
Tier 1: Preferred Generic	$0	$0
Tier 2: Generic	$0	$0
Tier 3: Preferred Brand	$45	$135
Tier 4: Non-Preferred Drug	$95	$285
Tier 5: Specialty Tier	33%	N/A

Your plan participates in the Insulin Savings Program. You will pay no more than $35 for a one-month (up to a 30-day) supply for Select Insulins, no matter what cost-sharing tier it's on. To identify which Select Insulins are included within the Insulin Savings Program, look for the ***ISP*** indicator in your Prescription Drug Guide. You are not eligible for this program if you receive "Extra Help".

Your plan also provides enhanced insulin coverage which means you will pay no more than $35 for a one-month (up to 30-day) supply for all Part D insulins covered by our plan, including Select Insulins, no matter what cost-sharing tier it's on. The enhanced insulin coverage is available, even if you receive "Extra Help".

Your share of the cost for Select Insulins:

Mail Order Cost-Sharing for Select Insulins				
Pharmacy options	**Standard** Walmart Mail, PillPack Other pharmacies are available in our network. To find pharmacy mail order options, go to **Humana.com/pharmacyfinder**		**Preferred** CenterWell Pharmacy™	
	30-day supply	**90-day supply***	**30-day supply**	**90-day supply***
Tier 3: Preferred Brand	**$35**	**$105**	**$35**	**$95**

Retail Cost-Sharing for Select Insulins		
Pharmacy options	**Retail** All network retail pharmacies. To find the retail pharmacies near you, go to **Humana.com/pharmacyfinder**	
	30-day supply	**90-day supply***
Tier 3: Preferred Brand	**$35**	**$105**

If you receive Extra Help for your drugs, you'll pay the following:
Deductible This plan does not have a deductible.

Pharmacy cost-sharing		
For generic drugs (including	**30-day supply**	**90-day supply***
brand drugs treated as generic), either:	**$0** copay; or **$1.45** copay; or **$4.15** copay ; or **15%** of the cost	**$0** copay; or **$1.45** copay; or **$4.15** copay ; or **15%** of the cost
For all other drugs, either:	**$0** copay; or **$4.30** copay; or **$10.35** copay ; or **15%** of the cost	**$0** copay; or **$4.30** copay; or **$10.35** copay ; or **15%** of the cost

Other pharmacies are available in our network.
*Some drugs are limited to a 30-day supply

ADDITIONAL DRUG COVERAGE

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 your prescription drug 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 retail pharmacy.

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

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 out-of-pocket costs total **$7,400** — which is the end of the coverage gap. 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 **$7,400** you pay the greater of:

- **5%** of the cost, or
- **$4.15** copay for generic (including brand drugs treated as generic) and a **$10.35** copay for all other drugs

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Additional Benefits

Medicare-covered foot care (podiatry)	**$45** 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 Cost share may vary depending on the service and where service is provided.	• Occupational and speech therapy: **$10** to **$40** copay • Cardiac rehabilitation: **$10** copay • Pulmonary rehabilitation: **$10** copay
Telehealth services (in addition to Original Medicare)	• Primary care provider (PCP): **$0** copay • Specialist: **$45** copay • Urgent care services: **$0** copay • Substance abuse and behavioral health services: **$0** copay

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.
This is a summary of what we cover. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of coverage and services. Visit **Humana.com/medicare** to view a copy of the EOC or call **1-800-833-2364**.

HMO Travel Benefit
Members can receive in-network benefits when services are received from a participating HMO National Network provider during their travels to other states and Puerto Rico.

Humana Well Dine® Meal Program
Humana's home delivered meal program for members following an inpatient stay in the hospital or nursing facility.

Special Supplemental Benefits for the Chronically Ill (SSBCI) Worry Free™ Meals
Members diagnosed with Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Congestive Heart Failure (CHF), or Depression, participating with care management services, and who meet program criteria may receive 2 meals per day for 12 weeks, 168 meals total. An additional 12 weeks of meals may be available as determined by the plan. Members may qualify for the Worry Free™ Meals program up to two times per plan year. There is no cost to participate. Authorization may be required.

Over-the-Counter (OTC) mail order
$25 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.

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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.

$24

MyOption Platinum Dental DEN887
Offers coverage for preventive, basic, and major services at both in-network (HumanaDental Medicare network) and out-of-network dentists. These extra benefits have an additional monthly premium.

$21.30

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.

$32.20

MyOption DEN206
Offers coverage for certain preventive, basic, and major services at both in-network (HumanaDental Medicare network) and out-of-network dentists. These extra benefits – in addition to your basic benefits – have an additional monthly premium.

$36

MyOption DEN207
Offers coverage for certain preventive, basic, and major services at both in-network (HumanaDental Medicare network) and out-of-network dentists. These extra benefits – in addition to your basic benefits – have an additional monthly premium.

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

Find out **more**

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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2023

Optional Supplemental Benefits

Humana Gold Plus H5619-041 (HMO)

Charlottesville

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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.

MyOption Platinum Dental (DEN887)

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

Here's how the benefit works:

Monthly Premium	**$24**		
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 exam	**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 per year
Periodontal maintenance	**0%**	**50%**	Four per 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%**	Unlimited per year
Recementation – Crown	**50%**	**55%**	One procedure every five years
Recementation – Bridge	**50%**	**55%**	One procedure every five years
Emergency treatment for pain	**50%**	**55%**	Two per year
Anesthesia	**0%**	**50%**	Unlimited per calendar year
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Root canal treatment	**70%**	**75%**	One per year
Crowns	**70%**	**75%**	Two per year
Periodontal scaling and root planing (deep cleaning)	**70%**	**75%**	One procedure for each quadrant per year
Scaling – generalized inflammation	**70%**	**75%**	One procedure per year
Complete dentures (including routine post-delivery care)	**70%**	**75%**	One upper and/or one lower complete denture every five years
Partial dentures (including routine post-delivery care)	**70%**	**75%**	One upper and/or one lower partial denture every five years
Denture adjustments (not covered within six months of initial placement)	**70%**	**75%**	One per year
Denture reline (not allowed on spare dentures)	**70%**	**75%**	One per year
Denture rebase (not covered if within six months of initial placement)	**70%**	**75%**	One procedure per year
Denture repair	**70%**	**75%**	One procedure per year
Tissue conditioning	**70%**	**75%**	One procedure per year
Occlusal adjustments	**70%**	**75%**	One procedure every three years
Oral surgery	**70%**	**75%**	Two per year

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

*Network dentists have agreed to provide services at a negotiated rate. If you see a network dentist, you cannot be billed more than that rate.

Out-of-network dentists have not agreed to provide services at contracted fees. 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. Please see below for provider locator instructions.

Dental services are subject to our standard claims review procedures which could include dental history to approve coverage. Dental benefits under this plan 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.**

MyOption Plus (DEN843 & VIS759)

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

Here's how the benefit works:

Monthly Premium	**$21.30**		
Annual Deductible	Dental: **$50** for basic services per calendar year Vision: There is no annual deductible		
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

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)			
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
$290 (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 is limited to one time use per year. Contact lenses will include conventional or disposable. The 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 **$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.

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Dental services are subject to our standard claims review procedures which could include dental history to approve coverage. Dental benefits under this plan 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.

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 (DEN206)

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	**$32.20**		
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 exam	**0%**	**0%**	Two procedures per year
Emergency diagnostic exam	**0%**	**0%**	One procedure per year
Periodontal Exam	**0%**	**0%**	One procedure every three years
Comprehensive oral evaluation	**0%**	**0%**	

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations Per Calendar Year
Preventive and Diagnostic Dental Services			
Bitewing X-rays	**0%**	**0%**	One set per year
Intraoral X-rays	**0%**	**0%**	One procedure per year
Panoramic or Diagnostic X-rays	**0%**	**0%**	One procedure every five years
Prophylaxis (cleaning)	**0%**	**0%**	Two procedures per year
Fluoride Treatment	**0%**	**0%**	Two procedures per year
Periodontal maintenance following periodontal therapy	**0%**	**0%**	Four procedures per year
Basic Dental Services (Minor Restorative)			
Amalgam restoration (silver filings)	**$25 Per tooth**	**$25 Per tooth**	Unlimited procedures per year
Composite resin restoration (white filings)	**$25 Per tooth**	**$25 Per tooth**	
Extraction, erupted tooth or exposed root	**$25 Per tooth**	**$25 Per tooth**	Unlimited procedures per year
Surgical removal of erupted tooth	**$25 Per tooth**	**$25 Per tooth**	
Recement crown	**$25**	**$25**	One procedure every five years
Recement Denture	**$25**	**$25**	One procedure every five years
Palliative (emergency) treatment of dental pain	**$25**	**$25**	Two procedures per year
Anesthesia	**0%**	**0%**	Unlimited 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
Root Canal	**50%**	**50%**	One per tooth per lifetime
Root Canal retreatment	**50%**	**50%**	One per tooth per lifetime
Crowns	**50%**	**50%**	One per tooth per lifetime
Onlay	**50%**	**50%**	
Inlay – alternate benefit only	**50%**	**50%**	

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)			
Tissue conditioning – maxillary (upper) or mandibular (lower)	**50%**	**50%**	One procedure code per year
Bridges	**50%**	**50%**	One procedure every five years.
Occlusal adjustment – limited	**50%**	**50%**	One procedure every three years
Occlusal adjustment – complete	**50%**	**50%**	
Oral Surgery	**50%**	**50%**	Two per year

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Dental services are subject to our standard claims review procedures which could include dental history to approve coverage. Dental benefits under this plan 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.**

MyOption (DEN207)

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	**$36**		
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 exam	**0%**	**0%**	Two procedures per year

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations Per Calendar Year
Preventive and Diagnostic Dental Services			
Emergency diagnostic exam	**0%**	**0%**	One procedure per year
Periodontal Exam	**0%**	**0%**	One procedure every three years
Comprehensive oral evaluation	**0%**	**0%**	
Bitewing X-rays	**0%**	**0%**	One set per year
Intraoral X-rays	**0%**	**0%**	One procedure per year
Panoramic or Diagnostic X-rays	**0%**	**0%**	One procedure every five years
Prophylaxis (cleaning)	**0%**	**0%**	Two procedures per year
Fluoride Treatment	**0%**	**0%**	Two procedures per year
Periodontal maintenance following periodontal therapy	**0%**	**0%**	Four procedures per year
Basic Dental Services (Minor Restorative)			
Amalgam restoration (silver filings)	**0%**	**0%**	Unlimited procedures per year
Composite resin restoration (white filings)	**0%**	**0%**	
Extraction, erupted tooth or exposed root	**0%**	**0%**	Unlimited procedures per year
Surgical removal of erupted tooth	**0%**	**0%**	
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**	
Recement fixed partial denture (bridge)	**$25**	**$25**	One procedure every five years
Palliative (emergency) treatment of dental pain	**$25**	**$25**	Two procedures per year
Anesthesia	**0%**	**0%**	Unlimited per year

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)			
Periodontal scaling and root planing	**0%**	**0%**	One procedure for each quadrant every three years
Scaling – moderate or severe gingival inflammation	**0%**	**0%**	One procedure every three years
Root canal	**50%**	**50%**	One procedure per tooth per lifetime
Root canal retreatment	**50%**	**50%**	One procedure per tooth per lifetime
Crowns	**50%**	**50%**	One procedure code per tooth per lifetime
Onlay	**50%**	**50%**	
Inlay – alternate benefit only	**50%**	**50%**	
Bridges - Pontic and retainer crown	**50%**	**50%**	One procedure every five years
Complete denture (including routine post-delivery care) – maxillary (upper) or mandibular (lower)	**50%**	**50%**	One upper complete and/or lower complete denture every five years
Immediate denture (including routine post-delivery care) – maxillary (upper) or mandibular (lower)	**50%**	**50%**	
Partial dentures (including routine post-delivery care) – resin or metal, maxillary (upper) or mandibular (lower)	**50%**	**50%**	One upper partial 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 code per year
Partial denture adjustment – 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)			
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%**	
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 code per year
Occlusal adjustment – limited	**50%**	**50%**	One procedure every three years
Occlusal adjustment – complete	**50%**	**50%**	
Oral surgery	**50%**	**50%**	Two procedures per year

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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 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.

Notes

Notes

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, ethnicity, marital status, religion, or language. 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.

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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-320-1235 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-320-1235 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-320-1235 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다 . 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-320-1235 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-320-1235 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugues: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-320-1235 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康健康保険と薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-877-320-1235 (TTY: 711) にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

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