

# 2017 Humana Medicare Advantage Plan Information

Thank you for your interest in applying for the Humana Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. You will be receiving an "Enrollment Verification Call" from Humana within 7 days of the application receipt.

Enrollment Packet – click links below to view the information

[Star Rating](#)

[Application Instructions](#)

Benefits: [Choice-009](#) / [Choice-012](#) / [Choice-013](#) / [Choice-073](#) / [Gold Choice-093](#) / [Gold Plus-153](#) / [Gold Plus-219](#)

[Provider Directory](#)

[Pharmacy Directory](#)

[Formulary](#)

[Multi-language Support](#)

## Initial Enrollment Period (IEP)

If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15<sup>th</sup> to December 7<sup>th</sup>. This will give you a January 1<sup>st</sup> effective date for your new plan.

## Annual Enrollment Period (AEP)

Applications must be signed and dated on, or between October 15<sup>th</sup> and December 7<sup>th</sup>. ***If they are signed prior to October 15<sup>th</sup> they will be returned to you with a new application.*** If they are received after December 7<sup>th</sup>, you will not be able to change plans until the next AEP for January of the following year.

## Special Enrollment Period (SEP)

There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc...

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

**CDA Insurance LLC**

PO Box 26540

Eugene, Oregon 97402

Fax: 1.541.284.2994 or 888.632.5470

Secure File Upload: [Click here](#)

Email: [cs@cda-insurance.com](mailto:cs@cda-insurance.com)

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613. Our website: <http://www.orhi.us>

Y0062\_MULTIPLAN\_CDA INSURANCE Oregon Accepted effective 7/31/2016

2017

# Summary of Benefits Optional Supplemental Benefits

HumanaChoice<sup>®</sup>  
H6609-073 (PPO)

Intermountain  
Select Counties in ID, OR and WA



**Humana**<sup>®</sup>

2017

# Summary of Benefits

HumanaChoice<sup>®</sup>  
H6609-073 (PPO)

Intermountain  
Select Counties in ID, OR and WA

**Humana**<sup>®</sup>

Our service area includes the following county/counties in Idaho, Oregon, Washington: Boise, Gem, Kootenai, ID;; Benton, Columbia, Crook, Deschutes, Hood River, Jefferson, Lincoln, Linn, Malheur, OR;; Cowlitz, Island, Kitsap, Kittitas, Walla Walla, WA;.



# Let's talk about **HumanaChoice<sup>®</sup>** **H6609-073 (PPO)**

Find out more about the HumanaChoice H6609-073 (PPO) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice H6609-073 (PPO) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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

## To be eligible

To join HumanaChoice H6609-073 (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

## Plan name:

HumanaChoice H6609-073 (PPO)

## How to reach us:

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

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

## October 1 - February 14:

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

## February 15 - September 30:

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

Or visit our website:

**Humana-medicare.com.**

As a member you must select an in-network doctor to act as your Primary Care Physician (PCP). HumanaChoice H6609-073 (PPO) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, you may be subject to higher copayments/coinsurance.



## A healthy partnership

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

**This document is available in other formats** such as Braille and large print. This information is available for free in other languages. Please contact a licensed Humana sales agent at 1-800-833-2364 (TTY: 711). Esta información está disponible gratuitamente en otros idiomas. Póngase en contacto con un agente de ventas certificado de Humana al 1-800-833-2364 (TTY: 711).



## Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
<b>PLAN COSTS</b>		
<b>Monthly premium</b> You must keep paying your Medicare Part B premium.	<b>\$201</b>	
<b>Medical deductible</b>	This plan does not have a deductible.	
<b>Pharmacy (Part D) deductible</b>	<b>\$300</b> only applies to Tier 3, Tier 4, Tier 5.	
<b>Maximum out-of-pocket responsibility</b> The most you pay for copays, coinsurance and other costs for medical services for the year.	<b>\$6,700</b> in-network	<b>\$10,000</b> combined in- and out-of-network



## Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>ACUTE INPATIENT HOSPITAL CARE</b>		
	<b>\$325</b> copay per day for days 1-4 <b>\$0</b> copay per day for days 5-90 Your plan covers an unlimited number of days for an inpatient stay	<b>30%</b> of cost
<b>DOCTOR OFFICE VISITS</b>		
<b>Primary care Physician (PCP)</b>	<b>\$0</b> copay	<b>30%</b> of cost
<b>Specialists</b>	<b>\$30</b> copay	<b>30%</b> of cost
<b>PREVENTIVE CARE</b>		
Including: Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Covered at no cost when you see an in-network provider. Any additional preventive services approved by Medicare during the contract year will be covered.	<b>Covered at no cost</b> when you see an in-network provider.	<b>0% to 30%</b> of the cost, depending on the service and where service is provided

You do not need a referral to receive covered services from in-network providers.

Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."



## Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
<b>EMERGENCY CARE</b>		
<b>Emergency room</b> 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.	<b>\$75</b> copay	<b>\$75</b> copay
<b>Urgently needed services</b> Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	<b>\$25</b> copay at an urgent care center	<b>30%</b> of cost at an urgent care center
<b>OUTPATIENT CARE AND DIAGNOSTIC SERVICES, LABS AND IMAGING</b>		
Cost share may vary depending on the service and where service is provided		
<b>Diagnostic Mammography</b>	<b>\$30</b> copay	<b>30%</b> of the cost
<b>Diagnostic radiology</b>	<b>\$225 to \$325</b> copay	<b>30%</b> of the cost
<b>Lab services</b>	<b>\$0 to \$30</b> copay	<b>30%</b> of the cost
<b>Diagnostic tests and procedures</b>	<b>\$0 to \$30</b> copay	<b>30%</b> of the cost
<b>Outpatient X-rays</b>	<b>\$0 to \$30</b> copay	<b>30%</b> of the cost
<b>Radiation Therapy</b>	<b>\$30</b> copay	<b>30%</b> of the cost
<b>HEARING SERVICES</b>		
<b>Medicare covered hearing</b>	<b>\$30</b> copay	<b>30%</b> of cost
<b>DENTAL SERVICES</b>		
<b>Medicare covered dental</b>	<b>\$30</b> copay	<b>30%</b> of cost

You do not need a referral to receive covered services from in-network providers.

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## Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
<b>Routine dental</b>	<ul style="list-style-type: none"> <li>• <b>0%</b> coinsurance for Panoramic Film up to 1 every 5 years.</li> <li>• <b>0%</b> coinsurance for extraoral X-rays, intraoral X-rays up to 1 per year.</li> <li>• <b>0%</b> coinsurance for Bitewing X-rays up to 1 set(s) per year.</li> <li>• <b>0%</b> coinsurance for Emergency Diagnostic Exam, Fluoride Treatment, Periodic Oral Exam and/or Comprehensive Oral Evaluation, Prophylaxis (cleaning) up to 2 per year.</li> <li>• <b>25%</b> coinsurance for Emergency treatment for pain up to 2 per year.</li> <li>• <b>25%</b> coinsurance for Extractions up to unlimited per year.</li> <li>• <b>50%</b> coinsurance for Composite Filling up to 1 every 3 years.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>50%</b> coinsurance for Panoramic Film up to 1 every 5 years.</li> <li>• <b>50%</b> coinsurance for extraoral X-rays, intraoral X-rays up to 1 per year.</li> <li>• <b>50%</b> coinsurance for Bitewing X-rays up to 1 set(s) per year.</li> <li>• <b>50%</b> coinsurance for Emergency Diagnostic Exam, Emergency treatment for pain, Fluoride Treatment, Periodic Oral Exam and/or Comprehensive Oral Evaluation, Prophylaxis (cleaning) up to 2 per year.</li> <li>• <b>50%</b> coinsurance for Extractions up to unlimited per year.</li> <li>• <b>55%</b> coinsurance for Composite Filling up to 1 every 3 years.</li> <li>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.</li> </ul>
<b>VISION SERVICES</b>		
<b>Medicare covered vision services</b>	<b>\$30</b> copay	<b>30%</b> of cost
<b>Glaucoma screening</b>	<b>\$0</b> copay	<b>30%</b> of cost
<b>Eyewear (post-cataract)</b>	<b>\$0</b> copay	<b>30%</b> of cost
<b>Routine vision</b>	<ul style="list-style-type: none"> <li>• <b>\$40</b> maximum benefit coverage amount per year for Routine Exam, which includes refraction, up to 1 per year. (Visit any in-network provider and your routine exam charge will not exceed the <b>\$40</b> maximum benefit coverage amount).</li> </ul>	<ul style="list-style-type: none"> <li>• <b>\$40</b> maximum benefit coverage amount per year for Routine Exam, which includes refraction, up to 1 per year.</li> <li>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.</li> </ul>

You do not need a referral to receive covered services from in-network providers.

Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."





## Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
<b>MENTAL HEALTH SERVICES</b>		
<b>Inpatient</b> Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	<b>\$325</b> copay per day for days 1-4 <b>\$0</b> copay per day for days 5-90	<b>30%</b> of cost
<b>Outpatient group and individual therapy visits</b>	<b>\$30</b> copay	<b>30%</b> of the cost
<b>SKILLED NURSING FACILITY</b>		
Your plan covers up to 100 days in a SNF	<b>\$0</b> copay per day for days 1-20 <b>\$164.50</b> copay per day for days 21-100	<b>30%</b> of cost
<b>REHABILITATION SERVICES</b>		
<b>Physical, occupational and speech therapy</b>	<b>\$30</b> copay	<b>30%</b> of the cost
<b>Cardiac and pulmonary rehabilitation</b>	<b>\$10</b> copay	<b>30%</b> of the cost
<b>AMBULANCE</b>		
<b>Ambulance (ground)</b>	<b>\$265</b> copay	<b>\$265</b> copay
<b>Ambulance (air)</b>	<b>20%</b> of cost	<b>20%</b> of cost
<b>TRANSPORTATION</b>		
	Not covered	Not covered
<b>FOOT CARE (PODIATRY)</b>		
<b>Medicare covered foot care</b>	<b>\$30</b> copay	<b>30%</b> of cost
<b>MEDICAL EQUIPMENT/SUPPLIES</b>		
<b>Durable medical equipment (like wheelchairs or oxygen)</b>	<b>20%</b> of the cost	<b>30%</b> of the cost
<b>Medical Supplies</b>	<b>20%</b> of cost	<b>30%</b> of cost
<b>Prosthetics (artificial limbs or braces)</b>	<b>20%</b> of cost	<b>30%</b> of cost
<b>Preferred diabetes monitoring supplies</b> Cost share may vary depending on where service is provided.	<b>0%</b> to <b>20%</b> of the cost	<b>30%</b> of the cost
<b>Non-preferred diabetes monitoring supplies</b> Cost share may vary depending on where service is provided.	<b>10%</b> to <b>20%</b> of the cost	<b>30%</b> of the cost

You do not need a referral to receive covered services from in-network providers.

Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."



## Covered Medical and Hospital Benefits (cont.)

### IN-NETWORK

### OUT-OF-NETWORK

#### FITNESS AND WELLNESS

SilverSneakers® Fitness Program - Basic fitness center membership including fitness classes.

The plan covers more benefits that promote health and well-being. To see more benefits, check out “More benefits with your plan,” listed later in this document.



## Prescription Drug Benefits

#### MEDICARE PART B DRUGS

<b>Chemotherapy drugs</b>	<b>20%</b> of the cost	<b>20%</b> of the cost
<b>Other part B drugs</b>	<b>20%</b> of the cost	<b>20%</b> of the cost

#### PRESCRIPTION DRUGS

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

You pay the following until your total yearly drug costs reach \$3,700. Total yearly drug costs are the total drug costs paid by both you and our plan.

<b>Tier</b>	<b>Preferred Retail Pharmacy</b>	<b>Standard Retail Pharmacy</b>	<b>Preferred Mail Order</b>	<b>Standard Mail Order</b>
<b>30-day supply</b>				
<b>1 (Preferred Generic)</b>	<b>\$4</b> copay	<b>\$9</b> copay	<b>\$4</b> copay	<b>\$9</b> copay
<b>2 (Generic)</b>	<b>\$15</b> copay	<b>\$20</b> copay	<b>\$15</b> copay	<b>\$20</b> copay
<b>3 (Preferred Brand)</b>	<b>\$42</b> copay	<b>\$47</b> copay	<b>\$42</b> copay	<b>\$47</b> copay
<b>4 (Non-Preferred Drug)</b>	<b>\$95</b> copay	<b>\$100</b> copay	<b>\$95</b> copay	<b>\$100</b> copay
<b>5 (Specialty)</b>	<b>27%</b> of cost	<b>27%</b> of cost	<b>27%</b> of cost	<b>27%</b> of cost
<b>90-day supply</b>				
<b>1 (Preferred Generic)</b>	<b>\$12</b> copay	<b>\$27</b> copay	<b>\$0</b> copay	<b>\$27</b> copay
<b>2 (Generic)</b>	<b>\$45</b> copay	<b>\$60</b> copay	<b>\$0</b> copay	<b>\$60</b> copay
<b>3 (Preferred Brand)</b>	<b>\$126</b> copay	<b>\$141</b> copay	<b>\$116</b> copay	<b>\$141</b> copay
<b>4 (Non-Preferred Drug)</b>	<b>\$285</b> copay	<b>\$300</b> copay	<b>\$275</b> copay	<b>\$300</b> copay

Specialty drugs are limited to a 30 day supply.

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

*You do not need a referral to receive covered services from in-network providers.*

*Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called “prior authorization” or “preauthorization.”*

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 medicine 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)

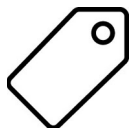
### Coverage Gap

After you enter the coverage gap, you pay **40 percent** of the plan's cost for covered brand name drugs and **51 percent** of the plan's cost for covered generic drugs until your costs total **\$4,950** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

### Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **\$4,950**, you pay the greater of:

- **5%** of the cost, or
- **\$3.30** copay for generic (including brand drugs treated as generic) and a **\$8.25** copayment for all other drugs



## More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

### **Additional smoking cessation**

A smoking cessation program available on-line, email and phone. Personal coaches assist via establishing goals and providing articles and resources to aid in the effort to quit smoking.

### **Counseling**

Member Assistance Program includes counseling by phone to help you cope with life changes, including adult care and child care issues. Online resources are also available.

### **Health education**

One-on-one wellness coaching with email, phone and online chat options.

### **Meals**

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

### **HumanaFirst nurse advice line**

Health advice from a registered nurse, available 24 hours a day, seven days a week.

### **Over-the-counter allowance**

**\$0** copay; up to **\$30** every 3 months for the purchase of OTC supplies from Humana Pharmacy mail delivery.

### **Go365™ by Humana**

Rewards for completing preventive health screenings and activities.



## Optional **Supplemental Benefits**

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

**\$31.90**

### **MyOption Enriched Dental PPO**

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

**\$15.30**

### **MyOption Vision**

Gives members access to the EyeMed Vision Care Select Network and provides additional vision benefits. These extra benefits - in addition to their basic benefits - have an additional monthly premium.

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



## Find out **more**

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You can see our plan's **provider and pharmacy directory** at our website at **[www.humana.com/members/tools](http://www.humana.com/members/tools)** or call us at the number listed at the beginning of this booklet and we will send you one.



You can see our plan's **drug formulary** at our website at **[www.humana.com/medicare/medicare\\_prescription\\_drugs/medicare\\_drug\\_tools/medicare\\_drug\\_list/](http://www.humana.com/medicare/medicare_prescription_drugs/medicare_drug_tools/medicare_drug_list/)** or call us at the number listed at the beginning of this booklet and we will send you one.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

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.

The provider/pharmacy network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Humana members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

2017

# Optional Supplemental Benefits

HumanaChoice®  
H6609-073 (PPO)

Intermountain  
Select Counties in ID, OR and WA

**Humana**®

## My Options, My Choice Adding Benefits to Your Plan

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

You can add these extra benefits when you sign up for your Medicare Advantage plan or any time during the year.

The information in this booklet will tell you about the benefits you can add to your plan. If you have questions, you can call us at 1-888-866-3154 (TTY: 711). We are available seven days a week, from 8 a.m. - 8 p.m. local time. However, please note that our automated phone system may answer your call during weekends and holidays from February 15 - September 30. Please leave your name and telephone number, and we will call you back by the end of the next business day.

### MyOption<sup>SM</sup> Vision

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

Here's how the benefit works:

<b>Monthly Premium</b>	<b>\$15.30</b>		
<b>Annual Deductible</b>	There is no annual deductible for all services		
<b>Maximum Benefit</b>	Humana pays up to <b>\$375</b> for one set of eyeglass frames and one pair of lenses <b>and/or</b> contact lenses (conventional or disposable) per calendar year		
<b>Covered Vision Benefits</b>	<b>EyeMed Network Vision Provider You Pay</b>	<b>Non-EyeMed Network Vision Provider* You Pay</b>	<b>Benefit Limitations</b>
Routine exam with refraction/dilation as necessary - <b>\$40</b> allowance	Any amount over <b>\$40</b>	Any amount over <b>\$40</b>	One Every 12 months
<b>\$375</b> (combined in and out-of-network) benefit toward the purchase and fitting of one set of eyeglass frames and one pair of lenses, <b>and/or</b> contact lenses at a network optical provider (conventional or disposable)  Eyeglass lens treatments to include UV and scratch resistance	Any amount over <b>\$375</b>	Any amount over <b>\$375</b>	Every 12 months

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



## OPTIONAL SUPPLEMENTAL BENEFITS (continued)

\*If you use a Non-EyeMed provider your share of the cost may be higher. When using an out-of-network provider, you will be responsible for costs above the plan-approved amount. You are responsible for submitting an EyeMed Vision Care out-of-network claim form with itemized receipt when seeing a Non-EyeMed select provider. Claim forms can be found on Myhumana.com.

### MyOption Dental Enriched<sup>SM</sup> PPO

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

Here's how the benefit works:

<b>Monthly Premium</b>	<b>\$31.90</b>		
<b>Annual Deductible</b>	There is no annual deductible for all services		
<b>Maximum Benefit</b>	Humana pays up to <b>\$1,500</b> per calendar year		
<b>Covered Dental Services</b>	<b>In-Network* You Pay</b>	<b>Out-Of- Network** You Pay</b>	<b>Benefit Limitations Per Calendar Year</b>
<b>Preventive and Diagnostic Dental Services</b>			
Oral examinations	<b>0%</b>	<b>50%</b>	Two per year
Dental prophylaxis (cleanings)	<b>0%</b>	<b>50%</b>	Two per year
Bitewing X-ray	<b>0%</b>	<b>50%</b>	One set per year
Intraoral X-rays	<b>0%</b>	<b>50%</b>	One set per year
Extraoral X-rays	<b>0%</b>	<b>50%</b>	One set per year
Panoramic and Diagnostic X-rays	<b>0%</b>	<b>50%</b>	One set every five years
Fluoride	<b>0%</b>	<b>50%</b>	Two per year
Emergency Exam	<b>0%</b>	<b>50%</b>	One per year
<b>Basic Dental Services (Minor Restorative)</b>			
Amalgam restorations (silver fillings)	<b>50%</b>	<b>50%</b>	One procedure every three years
Composite resin restorations (white fillings)***	<b>50%</b>	<b>50%</b>	
Extractions (pulling teeth), nonsurgical and surgical	<b>70%</b>	<b>70%</b>	Unlimited procedures per year
Emergency treatment for pain	<b>70%</b>	<b>70%</b>	Two per year
Anesthesia - frequent anesthesia	<b>0%</b>	<b>50%</b>	Unlimited procedures per year

**OPTIONAL SUPPLEMENTAL BENEFITS** (continued)

<b>Covered Dental Services</b>	<b>In-Network* You Pay</b>	<b>Out-Of- Network** You Pay</b>	<b>Benefit Limitations Per Calendar Year</b>
<b>Major Dental Services (Endodontics, Periodontics, and Oral Surgery)</b>			
Root canal treatment	<b>70%</b>	<b>70%</b>	One per year
Crowns	<b>70%</b>	<b>70%</b>	One per year
Periodontal scaling and root planing (deep cleaning)	<b>70%</b>	<b>70%</b>	Two procedures for each quadrant per year
Denture adjustments (not covered within six months of initial placement)	<b>70%</b>	<b>70%</b>	One per year
Complete dentures (including routine post-delivery care)	<b>70%</b>	<b>70%</b>	One upper and/or one lower complete denture every five years
Immediate dentures	<b>70%</b>	<b>70%</b>	One upper and/or one lower complete denture every five years
Partial dentures	<b>70%</b>	<b>70%</b>	One per year
Unilateral Partial dentures	<b>70%</b>	<b>70%</b>	One per year
Denture relines (not allowed on spare dentures)	<b>70%</b>	<b>70%</b>	One per year

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

\*Network dentists have agreed to provide services at an in-network rate. If you see a network dentist, you can't be billed more than the in-network rate.

\*\*If you see an out-of-network dentist, your share of the cost may be higher.

\*\*\* Composite resin restorations (white fillings) benefit as follows:

- Anterior (front) teeth: Composite restoration (white filling) benefit as previously displayed
- Posterior (back) teeth: Member is responsible for the remaining cost difference between a composite restoration (white filling) and an amalgam restoration (silver filling).

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

This information is available for free in other languages. Please call our customer service number at 1-800-457-4708, Monday - Sunday 8 a.m. - 8 p.m. TTY users, please call 711.

Esta información está disponible gratuitamente en otros idiomas. Comuníquese con el número de Atención al cliente al 1-800-457-4708, de lunes a domingo, de 8 a. m. a 8 p. m. Los usuarios de TTY deben llamar al 711.

**Humana**®

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## **Discrimination is Against the Law**

CHA HMO, INC., CAREPLUS HEALTH PLANS, INC., HUMANA MEDICAL PLAN, INC, HUMANA HEALTH PLAN, INC., HUMANA BENEFIT PLAN OF ILLINOIS, INC., HUMANA INSURANCE COMPANY, HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC., HUMANA INSURANCE OF PUERTO RICO, INC., HUMANA MEDICAL PLAN OF UTAH, INC., HUMANA HEALTH COMPANY OF NEW YORK, INC., HUMANA HEALTH PLANS OF PUERTO RICO, INC., HUMANA EMPLOYERS HEALTH PLAN OF GEORGIA, INC., HUMANA REGIONAL HEALTH PLAN, INC. CARITEN HEALTH PLAN INC., HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC., ARCADIAN HEALTH PLAN, INC., HUMANA INSURANCE COMPANY OF NEW YORK, HUMANA WI HEALTH ORGANIZATION INSURANCE CORP, HUMANA MEDICAL PLAN OF PENNSYLVANIA, INC., HUMANA MEDICAL PLAN OF MICHIGAN, INC. (“Humana”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats
- Provides free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Dr. Michelle Griffin, PhD.

If you believe that Humana has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Dr. Michelle M. Griffin, PhD (FACHE)

Civil Rights/LEP/ADA/Section 1557 Compliance Officer: 500 W. Main Street -10th floor Louisville, Kentucky 40202 Phone: 1-877-320-1235 Fax: 877-320-1269

Email: Mgriffin5@humana.com or Accessibility@humana.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Dr. Michelle Griffin PHD, Civil Rights/LEP/ADA/Section 1557 Compliance Officer is available to help you at the contact information listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

# Multi-Language Interpreter Services

**English:** ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-457-4708 (TTY: 711).

**Español (Spanish):** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-457-4708 (TTY: 711).

**繁體中文 (Chinese):** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-457-4708 (TTY: 711)。

**Tiếng Việt (Vietnamese):** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-457-4708 (TTY: 711).

**한국어 (Korean):** 주의 : 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-457-4708 (TTY: 711)번으로 전화해 주십시오.

**Tagalog (Tagalog – Filipino):** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-457-4708 (TTY: 711).

**Русский (Russian):** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-457-4708 (телетайп: 711).

**Kreyòl Ayisyen (French Creole):** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-457-4708 (TTY: 711).

**Français (French):** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-457-4708 (ATS : 711).

**Polski (Polish):** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-457-4708 (TTY: 711).

**Português (Portuguese):** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-457-4708 (TTY: 711).

**Italiano (Italian):** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-457-4708 (TTY: 711).

**Deutsch (German):** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-457-4708 (TTY: 711).

**日本語 (Japanese):** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-457-4708 (TTY: 711) まで、お電話にてご連絡ください。

**فارسی (Farsi):**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-457-4708 (رقم هاتف الصم والبكم: 711).

**Diné Bizaad (Navajo):** Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíłnih 1-800-457-4708 (TTY: 711)

**العربية (Arabic):**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-457-4708 (رقم هاتف الصم والبكم: 711).

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