

Summary of Benefits

**Humana Group Medicare Advantage PPO Plan
PPO 079/188**

**Kentucky Public Pensions Authority (KPPA) Medical Benefits for KPPA Essential and
Premium Prescription Drug Plans**

Humana®

Our service area includes specific counties within the United States, Puerto Rico and all other major U.S. territories.



Let's talk about the **Humana Group Medicare Advantage PPO Plan.**

Find out more about the Humana Group Medicare Advantage PPO plan – including the services it covers – in this easy-to-use guide.

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, refer to the "Evidence of Coverage."

To be eligible

To join the Humana Group Medicare Advantage PPO plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Humana Group Medicare Advantage PPO plan has a network of doctors, hospitals, and other providers. For more information, please call Humana Group Medicare Customer Care.

Plan name:

Humana Group Medicare Advantage PPO plan



A healthy partnership

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

How to reach us:

Members should call toll-free
1-855-267-1935 for questions
(TTY/TDD: 711)

Call Monday – Friday, 8 a.m. - 9 p.m.,
Eastern time.

Or visit our website:
<https://your.Humana.com/kppa>



Monthly Premium, Deductible and Limits

PLAN COSTS

Monthly premium

You must keep paying your Medicare Part B premium.

For information concerning the actual premiums you will pay, please contact your employer group benefits plan administrator.

Medical deductible

\$500 per year for some combined in- and out-of-network services

Medical Maximum out-of-pocket responsibility

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

In-Network Maximum Out-of-Pocket

\$1,200 out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; Dental Services (Routine); Fitness Program; Health Education Services; Meal Benefit; Personal Home Care; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; SSBCI Member Support; Smoking Cessation (Additional); Uniform Flexibility Non-Emergency Medical Transportation and the Plan Premium do not apply to the in-network maximum out-of-pocket.

If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.

Combined In and Out-of-Network Maximum Out-of-Pocket

\$1,200 out-of-pocket limit for Medicare-covered services.
In-Network Exclusions: Part D Pharmacy; Dental Services (Routine); Fitness Program; Health Education Services; Meal Benefit; Personal Home Care; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; SSBCI Member Support; Smoking Cessation (Additional); Uniform Flexibility Non-Emergency Medical Transportation and the Plan Premium do not apply to the combined maximum out-of-pocket.
Out-of-Network Exclusions: Part D Pharmacy, Dental Services (Routine); Worldwide Coverage and the Plan Premium do not apply to the combined maximum out-of-pocket.

Your limit for services received from in-network providers will count toward this limit.

If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://your.Humana.com/PAL). **Deductible may apply; please reference <https://your.Humana.com/kppa>.**



Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
This plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	\$231 per admit	\$231 per admit
OUTPATIENT HOSPITAL COVERAGE		
Diagnostic colonoscopy	4% of the cost	4% of the cost
Diagnostic mammography	4% of the cost	4% of the cost
Observation services	4% of the cost	4% of the cost
Surgery services	4% of the cost	4% of the cost
AMBULATORY SURGICAL CENTER		
Diagnostic colonoscopy	4% of the cost	4% of the cost
Surgery services	4% of the cost	4% of the cost
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	\$15 copay	\$15 copay
Specialists	\$25 copay	\$25 copay

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE		
This plan covers all Medicare preventative services including: • Abdominal aortic aneurysm screening • Alcohol misuse screening & counseling • Annual wellness visit • Bone mass measurement • Breast cancer screening • Cardiovascular disease behavioral therapy • Cardiovascular disease screening • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes self-management training • Diabetes screening • Glaucoma screening • Hepatitis C screening • HIV screening • Kidney disease education services • Lung cancer screening • Medical nutrition therapy • Obesity screening and therapy • Physical exams (routine) • Prostate cancer screening exam • Smoking and tobacco use cessation • STI screening and counseling • "Welcome to Medicare" preventative visit	Covered at no cost	Covered at no cost

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://your.Humana.com/PAL). **Deductible may apply; please reference <https://your.Humana.com/kppa>.**



Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
- Immunizations - Medicare diabetes prevention program (MDPP) Any additional preventative services approved by Medicare during the contract year will be covered.	Covered at no cost	Covered at no cost
EMERGENCY CARE		
Emergency room If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	\$65 copay for Medicare-covered emergency room visit(s)	\$65 copay for Medicare-covered emergency room visit(s)
Urgently needed services - Primary care provider (PCP) - Specialist's office - Urgent care center Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	\$15 copay \$25 copay \$45 copay	\$15 copay \$25 copay \$45 copay
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Advanced imaging services (MRI, MRA, PET and CT Scan) - Primary care provider (PCP) - Specialist's office - Freestanding radiological facility - Outpatient Hospital	\$15 copay \$25 copay 4% of the cost 4% of the cost	\$15 copay \$25 copay 4% of the cost 4% of the cost
Diagnostic mammography - Primary care provider (PCP) - Specialist's office - Freestanding radiological facility - Outpatient Hospital	\$15 copay \$25 copay 4% of the cost 4% of the cost	\$15 copay \$25 copay 4% of the cost 4% of the cost
Diagnostic procedures and tests Primary care provider (PCP)	\$15 copay	\$15 copay

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://your.humana.com/pal). **Deductible may apply; please reference <https://your.humana.com/kppa>.**



Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
• Specialist's office	\$25 copay	\$25 copay
• Urgent care center	\$45 copay	\$45 copay
• Freestanding radiological facility	4% of the cost	4% of the cost
• Outpatient Hospital	4% of the cost	4% of the cost
EKG screening		
• Primary care provider (PCP)	0% of the cost	0% of the cost
• Specialist's office	0% of the cost	0% of the cost
• Freestanding radiological facility	0% of the cost	0% of the cost
• Outpatient Hospital	0% of the cost	0% of the cost
Lab services		
• Primary care provider (PCP)	0% of the cost	0% of the cost
• Specialist's office	0% of the cost	0% of the cost
• Urgent care center	0% of the cost	0% of the cost
• Freestanding laboratory	0% of the cost	0% of the cost
• Outpatient Hospital	0% of the cost	0% of the cost
Nuclear medicine services		
• Freestanding radiological facility	4% of the cost	4% of the cost
• Outpatient Hospital	4% of the cost	4% of the cost
Outpatient x-rays		
• Primary care provider (PCP)	\$15 copay	\$15 copay
• Specialist's office	\$25 copay	\$25 copay
• Urgent care center	\$45 copay	\$45 copay
• Freestanding radiological facility	4% of the cost	4% of the cost
• Outpatient Hospital	4% of the cost	4% of the cost
Radiation therapy		
• Specialist's office	\$25 copay	\$25 copay
• Freestanding radiological facility	4% of the cost	4% of the cost
• Outpatient Hospital	4% of the cost	4% of the cost
HEARING SERVICES		
Medicare-covered hearing: diagnostic hearing and balance exams	\$25 copay	\$25 copay
DENTAL SERVICES		
Medicare-covered dental	\$25 copay	\$25 copay

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
Routine dental	\$1,000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits including bitewing x-rays, periodic oral exam, prophylaxis (cleaning) up to 1 per year, comprehensive oral evaluation or periodontal exam up to 1 every 3 years, necessary anesthesia with covered service up to as needed with covered codes per year. 50% of the cost for amalgam or composite filling up to 1 per year.	\$1,000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits including bitewing x-rays, periodic oral exam, prophylaxis (cleaning) up to 1 per year, comprehensive oral evaluation or periodontal exam up to 1 every 3 years, necessary anesthesia with covered service up to as needed with covered codes per year. 50% of the cost for amalgam or composite filling up to 1 per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Limitations and exclusions may apply. Please see your Evidence of Coverage (EOC) for additional details. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. Dental benefits under this plan may not cover all ADA procedure codes. Any services received that are not listed will not be covered by the plan and will be the member's responsibility. The member is responsible for any amount above the dental coverage limit. Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. Information regarding each plan is available at **[Humana.com/sb](https://www.humana.com/sb)**.

In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule (but any applicable coinsurance payment still applies). Visiting an in-network provider may result in significant savings.

Out-of-network dentists have not agreed to provide services at contracted fees. The out-of-network provider may bill the member for more than what the plan pays, even for services listed with no member cost share. Members are responsible for this difference between Humana's reimbursement and the out-of-network provider's charges. This is known as balance billing. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Please see below for provider locator instructions. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement. The coinsurance level will apply to the average negotiated in-network fee schedule (INFS)/usual-customary and reasonable fees in your area. See Chapter 2 Payment Requests Contact Information or visit [Humana.com](https://www.humana.com) for information on requesting reimbursement.

The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. Contact Customer Service to locate a provider.

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
VISION SERVICES		
Medicare-covered vision services	\$25 copay	\$25 copay
Medicare-covered diabetic eye exam (1 per year)	0% of the cost	0% of the cost
Medicare-covered glaucoma screening (1 per year)	0% of the cost	0% of the cost
Medicare-covered eyewear (post-cataract)	\$25 copay	\$25 copay
MENTAL HEALTH SERVICES		
Inpatient The inpatient hospital care limit applies to inpatient mental services provided in a general hospital or a psychiatric facility. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. 190 day lifetime limit in a psychiatric facility.	\$231 per admit	\$231 per admit
Partial Hospitalization	4% of the cost	4% of the cost
Intensive Outpatient Services	4% of the cost	4% of the cost
Outpatient group and individual therapy visits		
• Primary care provider (PCP)	\$15 copay	\$15 copay
• Specialist's office	\$25 copay	\$25 copay
• Urgent care	\$45 copay	\$45 copay
• Outpatient Hospital	4% of the cost	4% of the cost
SKILLED NURSING FACILITY (SNF)		
This plan covers up to 365 days in a SNF.	\$0 copay per day for days 1-20 \$29 copay per day for days 21-100	\$0 copay per day for days 1-20 \$29 copay per day for days 21-100
No 3-day hospital stay is required. Plan pays \$0 after 365 days.	20% of the cost per stay for days 101-365	20% of the cost per stay for days 101-365

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://your.Humana.com/PAL). **Deductible may apply; please reference <https://your.Humana.com/kppa>.**



Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
AMBULANCE		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	4% of the cost	4% of the cost
TRANSPORTATION		
Uniform Flexibility Non-Emergency Medical Transportation	\$0 copay for plan approved location up to unlimited one-way trip(s) per year by car, rideshare services, van, wheelchair access vehicle for members with a Chronic Kidney Disease (CKD), End Stage Renal Disease (ESRD), or Cancer Diagnosis. This benefit is not to exceed 50 miles per trip.	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
MEDICARE PART B PRESCRIPTION DRUGS		
Chemotherapy drugs		
• Specialist's office	\$25 copay	\$25 copay
• Outpatient Hospital	4% of the cost	4% of the cost
Medicare Part B covered drugs		
• Primary care provider (PCP)	\$15 copay	\$15 copay
• Specialist's office	\$25 copay	\$25 copay
• Outpatient Hospital	\$25 copay	\$25 copay
• Pharmacy	4% of the cost	4% of the cost
Medicare Part B insulin drugs		
• Primary care provider (PCP)	\$15 copay	\$15 copay
• Specialist's office	\$25 copay	\$25 copay
• Outpatient Hospital	\$25 copay	\$25 copay
• Pharmacy	4% of the cost	4% of the cost
You will pay no more than \$35 for a one-month (up to 30-day) supply for all Part B insulin covered by our plan, and if your plan has a deductible it does not apply to Part B insulin.		

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://your.Humana.com/PAL). **Deductible may apply; please reference <https://your.Humana.com/kppa>.**



Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUPUNCTURE SERVICES		
Medicare-covered acupuncture visit(s) for chronic low back pain	\$25 copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year.	\$25 copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
ALLERGY		
Allergy shots & serum		
• Primary care provider (PCP)	\$15 copay	\$15 copay
• Specialist's office	\$25 copay	\$25 copay
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	4% of the cost	4% of the cost
DIABETES SERVICES AND SUPPLIES		
Continuous glucose monitor (CGM)		
• Durable medical equipment provider	4% of the cost	4% of the cost
• Pharmacy	4% of the cost	4% of the cost
Diabetes management training		
• Primary care provider (PCP)	0% of the cost	0% of the cost
• Specialist's office	0% of the cost	0% of the cost
• Outpatient hospital	0% of the cost	0% of the cost
Diabetes monitoring supplies		
• Durable medical equipment provider	0% of the cost	0% of the cost
• Pharmacy	0% of the cost	0% of the cost
• Preferred diabetic supplier	\$0 copay	Not Covered
Diabetes screening		
• Primary care provider (PCP)	0% of the cost	0% of the cost
• Specialist's office	0% of the cost	0% of the cost
FOOT CARE (PODIATRY)		
Medicare-covered foot care	\$25 copay	\$25 copay
HOME HEALTH CARE		
	0% of the cost	0% of the cost

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://your.Humana.com/PAL). **Deductible may apply; please reference <https://your.Humana.com/kppa>.**



Covered Medical Benefits

IN-NETWORK

OUT-OF-NETWORK

HOSPICE

You must get care from a Medicare-certified hospice. You must consult with this plan before you select hospice.

MEDICAL EQUIPMENT/SUPPLIES

Durable medical equipment

• Durable medical equipment provider	4% of the cost	4% of the cost
• Pharmacy	4% of the cost	4% of the cost

Medical supplies (includes but not limited to: catheters, IV set-up and supplies)

• Medical supply provider	4% of the cost	4% of the cost
• Pharmacy	4% of the cost	4% of the cost

Prosthetics (artificial limbs or braces)

• Prosthetics provider	4% of the cost	4% of the cost
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OUTPATIENT SUBSTANCE ABUSE

Outpatient group and individual substance abuse treatment visits

• Primary care provider (PCP)	\$15 copay	\$15 copay
• Specialist's office	\$25 copay	\$25 copay
• Urgent care	\$45 copay	\$45 copay
• Outpatient hospital	4% of the cost	4% of the cost

PRIVATE DUTY NURSING

• Member's home	20% of the cost	20% of the cost
• Inpatient Hospital	20% of the cost	20% of the cost

\$2,500 combined In &
Out-of-Network maximum
benefit coverage amount per
year

REHABILITATION SERVICES

Audiology Therapy

• Specialist's office	4% of the cost	4% of the cost
• Comprehensive outpatient rehab facility	4% of the cost	4% of the cost
• Outpatient hospital	4% of the cost	4% of the cost

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
Cardiac rehabilitation		
• Specialist's office	4% of the cost	4% of the cost
• Outpatient hospital	4% of the cost	4% of the cost
Occupational therapy		
• Specialist's office	4% of the cost	4% of the cost
• Comprehensive outpatient rehab facility	4% of the cost	4% of the cost
• Outpatient hospital	4% of the cost	4% of the cost
Physical therapy		
• Specialist's office	4% of the cost	4% of the cost
• Comprehensive outpatient rehab facility	4% of the cost	4% of the cost
• Outpatient hospital	4% of the cost	4% of the cost
Pulmonary rehabilitation		
• Specialist's office	4% of the cost	4% of the cost
• Comprehensive outpatient rehab facility	4% of the cost	4% of the cost
• Outpatient hospital	4% of the cost	4% of the cost
Speech therapy		
• Specialist's office	4% of the cost	4% of the cost
• Comprehensive outpatient rehab facility	4% of the cost	4% of the cost
• Outpatient hospital	4% of the cost	4% of the cost
RENAL DIALYSIS		
Renal dialysis services		
• Dialysis center	4% of the cost	4% of the cost
• Outpatient hospital	4% of the cost	4% of the cost
Kidney disease education services		
• Primary care provider (PCP)	0% of the cost	0% of the cost
• Specialist's office	0% of the cost	0% of the cost
• Outpatient hospital	0% of the cost	0% of the cost
HUMANA IN-NETWORK TELEHEALTH VENDORS, i.e. MDLive (in addition to Original Medicare)		
Primary care provider (PCP)	\$0 copay	Not Covered
Specialist	\$25 copay	Not Covered
Urgent care services	\$0 copay	Not Covered
Substance abuse or behavioral health services	\$0 copay	Not Covered

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Additional Benefits

FITNESS AND WELLNESS

Live a healthier, more active life through fitness and social connection at participating SilverSneakers® locations and online.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

HEALTH EDUCATION SERVICES

Personal Health Coaching is an interactive inbound and outreach on-line and telephonic wellness coaching for Medicare participants who elect to participate, for wellness improvement, including weight management, nutrition, exercise, back care, blood pressure management, and blood sugar management.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

POST-DISCHARGE SERVICES

\$0 copay for the following benefits per discharge event following each inpatient or skilled nursing facility stay:

- Assistance from a qualified aid to help perform activities of daily living within the home. Minimum of 4 hours per day, up to a maximum of 8 hours. Types of assistance include bathing, dressing, toileting, walking, eating and preparing meals.
- 2 meals per day for 14 days, up to 28 meals delivered to your door.
- Transportation to plan approved locations by rideshare services, car, van or wheelchair accessible vehicle.

Services must be provided by approved vendors, scheduled within 30 days of discharge event and utilized within 60 days of discharge.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

SMOKING CESSATION (ADDITIONAL)

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

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

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This image shows a blank sheet of white paper with horizontal ruling lines. At the very top, there is a dashed black line. Below it are several solid grey horizontal lines spaced evenly apart, providing a guide for handwriting practice. The rest of the page is completely blank.

This image shows a blank sheet of white paper designed for handwriting practice. It features a series of horizontal lines spaced evenly down the page. At the very top, there is a dashed line, followed by a solid line, and then several more solid lines below. The lines are thin and light gray or blue in color. There is no text or other markings on the page.

Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available. Call **877-320-1235 (TTY: 711)**.

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسيق البديل مجانًا. اتصل على الرقم **877-320-1235 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Չանգահարե՛ք՝ **877-320-1235 (TTY: 711)**:

বাংলা [Bengali]: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **877-320-1235 (TTY: 711)** নম্বরে।

简体中文 [Simplified Chinese]: 我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 **877-320-1235 (听障专线: 711)**。

繁體中文 [Traditional Chinese]: 我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 **877-320-1235 (聽障專線: 711)**。

Kreyòl Ayisyen [Haitian Creole]: Lang gratis, èd oksilyè, ak lòt fòm sèvis disponib. Rele **877-320-1235 (TTY: 711)**.

Hrvatski [Croatian]: Dostupni su besplatni jezik, dodatna pomoć i usluge alternativnog formata. Nazovite **877-320-1235 (TTY: 711)**.

فارسی [Farsi]: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **877-320-1235 (TTY: 711)** تماس بگیرید.

Français [French]: Des services gratuits linguistiques, d'aide auxiliaire et de mise au format sont disponibles. Appeler le **877-320-1235 (TTY: 711)**.

Deutsch [German]: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **877-320-1235 (TTY: 711)**.

Ελληνικά [Greek]: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **877-320-1235 (TTY: 711)**.

ગુજરાતી [Gujarati]: નિ:શુલ્ક ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **877-320-1235 (TTY: 711)** પર કોલ કરો.

עברית [Hebrew]: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **877-320-1235 (TTY: 711)**.

हिन्दी [Hindi]: नि:शुल्क भाषा, सहायक मदद और वैकल्पिक प्रारूप सेवाएं उपलब्ध हैं। **877-320-1235 (TTY: 711)** पर कॉल करें।

Hmoob [Hmong]: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **877-320-1235 (TTY: 711)**.

Italiano [Italian]: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiama il numero **877-320-1235 (TTY: 711)**.

This notice is available at <https://www.humana.com/legal/multi-language-support>.

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日本語 [Japanese]: 言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。**877-320-1235 (TTY: 711)** までお電話ください。

ភាសាខ្មែរ [Khmer]: សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជំនួយប្រភេទផ្សេងៗដល់សហគមន៍កាន់ ទូរសព្ទទៅលេខ **877-320-1235 (TTY: 711)**។

한국어 [Korean]: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다.
877-320-1235 (TTY: 711)번으로 문의하십시오.

ພາສາລາວ [Lao]: ມີການບໍລິການດ້ານພາສາ, ອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ຊບແບບທາງເລືອກອື່ນໃຫ້ໃຊ້ໄດ້.
ໂທ **877-320-1235 (TTY: 711)**.

Diné [Navajo]: Saad t'áá jiik'eh, t'áadoole'é binahji' bee adahodooníílgíí diné bich'í' anídahazt'i'í, dóó łahgo át'éego bee hada' dilyaaígíí bee bika'aanída'awo'í dahóló. Kohji' hodílnih **877-320-1235 (TTY: 711)**.

Polski [Polish]: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **877-320-1235 (TTY: 711)**.

Português [Portuguese]: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **877-320-1235 (TTY: 711)**.

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। **877-320-1235 (TTY: 711)** 'ਤੇ ਕਾਲ ਕਰੋ।

Русский [Russian]: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **877-320-1235 (TTY: 711)**.

Español [Spanish]: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al **877-320-1235 (TTY: 711)**.

Tagalog [Tagalog]: Magagamit ang mga libreng serbisyon pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **877-320-1235 (TTY: 711)**.

தமிழ் [Tamil]: இலவச மொழி, துணை உதவி மற்றும் மாற்று வடிவ சேவைகள் உள்ளன. **877-320-1235 (TTY: 711)** ஐ அழைக்கவும்.

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **877-320-1235 (TTY: 711)** కి కాల్ చేయండి.

877-320-1235 (TTY: 711) اردو: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔

Tiếng Việt [Vietnamese]: Có sẵn các dịch vụ miễn phí về ngôn ngữ, hỗ trợ bổ sung và định dạng thay thế. Hãy gọi **877-320-1235 (TTY: 711)**.

አማርኛ [Amharic]: ቋንቋ፣ ኢንተር ማዳመጫ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችም ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

Bàsàw` [Bassa]: Wuḍu-xwíniín-mú-zà-zà kùà, Hwòdǒ-fóhó-nyo, kè nyo-boŭn-po-kà bě bé nyuɛɛ se wíqí pèè-pèè dò kò. **877-320-1235 (TTY: 711)** dá.

Bekee [Igbo]: Asụsụ n'efu, enyemaka nkwarụ, na ọrụ usoro ndị ọzọ dị. Kpọọ **877-320-1235 (TTY: 711)**.

Òyìnbó [Yoruba]: Àwọn isẹ àtìlẹ̀hìn ìrànlọ́wọ́ èdè, àtì ọ̀nà kíkà mírán wà lárọ̀wọ́tọ́. Pe **877-320-1235 (TTY: 711)**.

नेपाली [Nepali]: भाषासम्बन्धी निःशुल्क, सहायक साधन र वैकल्पिक फार्मेट (ढाँचा/व्यवस्था) सेवाहरू उपलब्ध छन् । **877-320-1235 (TTY: 711)** मा कल गर्नुहोस् ।



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