

# Summary of Benefits

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**Humana Group Medicare Advantage PPO Plan  
PPO 079/313**

**CTA Retiree Health Care Plan**

**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."

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## **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!

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## **How to reach us:**

Members should call toll-free  
**1-800-542-2070** for questions  
(TTY/TDD: 711)

Call Monday – Friday, 7 a.m. – 8 p.m.,  
Central time.

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



## 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**

**\$390** 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**

**\$3,901** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; Fitness Program; Health Education Services; Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Uniform Flexibility Non-Emergency Medical Transportation; Uniform Flexibility Virtual Cardiac Recovery Program 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**

**\$3,901** out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy; Fitness Program; Health Education Services; Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Uniform Flexibility Non-Emergency Medical Transportation; Uniform Flexibility Virtual Cardiac Recovery Program and the Plan Premium do not apply to the combined maximum out-of-pocket.

Out-of-Network Exclusions: Part D Pharmacy, Fitness Program; Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Uniform Flexibility Non-Emergency Medical Transportation; Uniform Flexibility Virtual Cardiac Recovery Program; 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://www.humana.com/PAL).



## Covered Medical Benefits

|                                                                                                                                                                                        | IN-NETWORK                              | OUT-OF-NETWORK                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|
| <b>ACUTE INPATIENT HOSPITAL CARE</b>                                                                                                                                                   |                                         |                                         |
| 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. | <b>\$200</b> copay per day for days 1-7 | <b>\$200</b> copay per day for days 1-7 |
| <b>OUTPATIENT HOSPITAL COVERAGE</b>                                                                                                                                                    |                                         |                                         |
| <b>Diagnostic colonoscopy</b>                                                                                                                                                          | <b>10%</b> of the cost                  | <b>10%</b> of the cost                  |
| <b>Diagnostic mammography</b>                                                                                                                                                          | <b>10%</b> of the cost                  | <b>10%</b> of the cost                  |
| <b>Observation services</b>                                                                                                                                                            | <b>10%</b> of the cost                  | <b>10%</b> of the cost                  |
| <b>Surgery services</b>                                                                                                                                                                | <b>10%</b> of the cost                  | <b>10%</b> of the cost                  |
| <b>AMBULATORY SURGICAL CENTER</b>                                                                                                                                                      |                                         |                                         |
| <b>Diagnostic colonoscopy</b>                                                                                                                                                          | <b>10%</b> of the cost                  | <b>10%</b> of the cost                  |
| <b>Surgery services</b>                                                                                                                                                                | <b>10%</b> of the cost                  | <b>10%</b> of the cost                  |
| <b>DOCTOR OFFICE VISITS</b>                                                                                                                                                            |                                         |                                         |
| <b>Primary care provider (PCP)</b>                                                                                                                                                     | <b>0%</b> of the cost                   | <b>0%</b> of the cost                   |
| <b>Specialists</b>                                                                                                                                                                     | <b>10%</b> of the cost                  | <b>10%</b> of the cost                  |

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# Covered Medical Benefits

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | IN-NETWORK                | OUT-OF-NETWORK            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|---------------------------|
| <b>PREVENTIVE CARE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                           |                           |
| <p>This plan covers all Medicare preventative services including:</p> <ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening</li> <li>• Alcohol misuse screening &amp; counseling</li> <li>• Annual wellness visit</li> <li>• Bone mass measurement</li> <li>• Breast cancer screening</li> <li>• Cardiovascular disease behavioral therapy</li> <li>• Cardiovascular disease screening</li> <li>• Cervical and vaginal cancer screening</li> <li>• Colorectal cancer screening</li> <li>• Depression screening</li> <li>• Diabetes self-management training</li> <li>• Diabetes screening</li> <li>• Glaucoma screening</li> <li>• Hepatitis C screening</li> <li>• HIV screening</li> <li>• Kidney disease education services</li> <li>• Lung cancer screening</li> <li>• Medical nutrition therapy</li> <li>• Obesity screening and therapy</li> <li>• Physical exams (routine)</li> <li>• Prostate cancer screening exam</li> <li>• Smoking and tobacco use cessation</li> <li>• STI screening and counseling</li> <li>• "Welcome to Medicare" preventative visit</li> </ul> | <b>Covered at no cost</b> | <b>Covered at no cost</b> |
| <ul style="list-style-type: none"> <li>• Immunizations</li> <li>• Medicare diabetes prevention program (MDPP)</li> </ul> <p>Any additional preventative services approved by Medicare during the contract year will be covered.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>Covered at no cost</b> | <b>Covered at no cost</b> |

**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://www.humana.com/PAL).



# Covered Medical Benefits

|                                                                                                                                                                                                                                                                                                                                           | IN-NETWORK                                                                                                               | OUT-OF-NETWORK                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| <b>EMERGENCY CARE</b>                                                                                                                                                                                                                                                                                                                     |                                                                                                                          |                                                                                                                          |
| <b>Emergency room</b><br>If you are admitted to the hospital within 48 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.                                                                                         | <b>\$65</b> copay for Medicare-covered emergency room visit(s)                                                           | <b>\$65</b> copay for Medicare-covered emergency room visit(s)                                                           |
| <b>Urgently needed services</b><br><ul style="list-style-type: none"> <li>Primary care provider (PCP)</li> <li>Specialist's office</li> <li>Urgent care center</li> </ul> Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. | <b>0%</b> of the cost<br><b>10%</b> of the cost<br><b>\$50</b> copay                                                     | <b>0%</b> of the cost<br><b>10%</b> of the cost<br><b>\$50</b> copay                                                     |
| <b>DIAGNOSTIC SERVICES, LABS AND IMAGING</b>                                                                                                                                                                                                                                                                                              |                                                                                                                          |                                                                                                                          |
| <b>Advanced imaging services (MRI, MRA, PET and CT Scan)</b><br><ul style="list-style-type: none"> <li>Primary care provider (PCP)</li> <li>Specialist's office</li> <li>Freestanding radiological facility</li> <li>Outpatient Hospital</li> </ul>                                                                                       | <b>0%</b> of the cost<br><b>10%</b> of the cost<br><b>10%</b> of the cost<br><b>10%</b> of the cost                      | <b>0%</b> of the cost<br><b>10%</b> of the cost<br><b>10%</b> of the cost<br><b>10%</b> of the cost                      |
| <b>Diagnostic mammography</b><br><ul style="list-style-type: none"> <li>Primary care provider (PCP)</li> <li>Specialist's office</li> <li>Freestanding radiological facility</li> <li>Outpatient Hospital</li> </ul>                                                                                                                      | <b>0%</b> of the cost<br><b>10%</b> of the cost<br><b>10%</b> of the cost<br><b>10%</b> of the cost                      | <b>0%</b> of the cost<br><b>10%</b> of the cost<br><b>10%</b> of the cost<br><b>10%</b> of the cost                      |
| <b>Diagnostic procedures and tests</b><br><ul style="list-style-type: none"> <li>Primary care provider (PCP)</li> <li>Specialist's office</li> <li>Urgent care center</li> <li>Freestanding radiological facility</li> <li>Outpatient Hospital</li> </ul>                                                                                 | <b>0%</b> of the cost<br><b>10%</b> of the cost<br><b>\$50</b> copay<br><b>10%</b> of the cost<br><b>10%</b> of the cost | <b>0%</b> of the cost<br><b>10%</b> of the cost<br><b>\$50</b> copay<br><b>10%</b> of the cost<br><b>10%</b> of the cost |
| <b>EKG screening</b><br><ul style="list-style-type: none"> <li>Primary care provider (PCP)</li> <li>Specialist's office</li> </ul>                                                                                                                                                                                                        | <b>0%</b> of the cost<br><b>0%</b> of the cost                                                                           | <b>0%</b> of the cost<br><b>0%</b> 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://www.humana.com/PAL).



## Covered Medical Benefits

|                                      | IN-NETWORK      | OUT-OF-NETWORK  |
|--------------------------------------|-----------------|-----------------|
| • Freestanding radiological facility | 0% of the cost  | 0% of the cost  |
| • Outpatient Hospital                | 0% of the cost  | 0% of the cost  |
| <b>Lab services</b>                  |                 |                 |
| • Primary care provider (PCP)        | 0% of the cost  | 0% of the cost  |
| • Specialist's office                | 10% of the cost | 10% of the cost |
| • Urgent care center                 | 10% of the cost | 10% of the cost |
| • Freestanding laboratory            | 10% of the cost | 10% of the cost |
| • Outpatient Hospital                | 10% of the cost | 10% of the cost |
| <b>Nuclear medicine services</b>     |                 |                 |
| • Freestanding radiological facility | 10% of the cost | 10% of the cost |
| • Outpatient Hospital                | 10% of the cost | 10% of the cost |
| <b>Outpatient x-rays</b>             |                 |                 |
| • Primary care provider (PCP)        | 0% of the cost  | 0% of the cost  |
| • Specialist's office                | 10% of the cost | 10% of the cost |
| • Urgent care center                 | \$50 copay      | \$50 copay      |
| • Freestanding radiological facility | 10% of the cost | 10% of the cost |
| • Outpatient Hospital                | 10% of the cost | 10% of the cost |
| <b>Radiation therapy</b>             |                 |                 |
| • Specialist's office                | 10% of the cost | 10% of the cost |
| • Freestanding radiological facility | 10% of the cost | 10% of the cost |
| • Outpatient Hospital                | 10% of the cost | 10% of the cost |



## HEARING SERVICES

|                                                                       |                 |                 |
|-----------------------------------------------------------------------|-----------------|-----------------|
| <b>Medicare-covered hearing: diagnostic hearing and balance exams</b> | 10% of the cost | 10% 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://www.humana.com/PAL).



## Covered Medical Benefits

|                        | IN-NETWORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | OUT-OF-NETWORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Routine hearing</b> | <p><b>\$0</b> copay for routine hearing exams up to 1 per year (includes hearing aid fitting).</p> <p><b>\$0</b> copay for follow-up provider visits up to 3 per year.</p> <p><b>\$2,000</b> maximum benefit coverage amount for hearing aid(s) (all types) up to 2 every 3 years.</p> <p>Note: Includes 3 years of batteries per non-rechargeable aid (up to 60 cells per ear, per year) and 3 year warranty.</p> <p>Three follow-up provider visits during first year following hearing aid purchase, with the original provider.</p> | <p><b>95%</b> of the cost for routine hearing exams up to 1 per year.</p> <p><b>95%</b> of the cost for follow-up provider visits up to 3 per year.</p> <p><b>95%</b> of the cost for each prescription hearing aid up to 2 every 3 years.</p> <p>Member is required to pay the full cost at the time of service when utilizing an out-of-network provider.</p> <p>To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to <b>5%</b> of the allowed amount on eligible items/services.</p> <p>Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.</p> |



### DENTAL SERVICES

|                                |                        |                        |
|--------------------------------|------------------------|------------------------|
| <b>Medicare-covered dental</b> | <b>10%</b> of the cost | <b>10%</b> of the cost |
|--------------------------------|------------------------|------------------------|



### VISION SERVICES

|                                                         |                        |                        |
|---------------------------------------------------------|------------------------|------------------------|
| <b>Medicare-covered vision services</b>                 | <b>10%</b> of the cost | <b>10%</b> of the cost |
| <b>Medicare-covered diabetic eye exam (1 per year)</b>  | <b>0%</b> of the cost  | <b>0%</b> of the cost  |
| <b>Medicare-covered glaucoma screening (1 per year)</b> | <b>0%</b> of the cost  | <b>0%</b> of the cost  |
| <b>Medicare-covered eyewear (post-cataract)</b>         | <b>10%</b> of the cost | <b>10%</b> of the cost |

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## Covered Medical Benefits

|                                                                                                                                                                                                                                                                                                                     | IN-NETWORK                                                                                                                                                                                                                                                                                                                        | OUT-OF-NETWORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Routine vision</b><br><br><b>EyeMed</b> is the In-Network provider for the routine vision benefit. Contact Customer Service to locate a provider.                                                                                                                                                                | <b>\$10</b> copay for routine exam (includes refraction) up to 1 per year.<br><b>\$250</b> combined maximum benefit coverage amount per year for contact lenses, eyeglasses (lenses and frames), including lens options such as ultraviolet protection and scratch resistant coating, fitting for eyeglasses (lenses and frames). | <b>\$10</b> copay for routine exam (includes refraction) up to 1 per year.<br><b>\$165</b> combined maximum benefit coverage amount per year for routine exam (includes refraction).<br><b>\$250</b> combined maximum benefit coverage amount per year for contact lenses, eyeglasses (lenses and frames), including lens options such as ultraviolet protection and scratch resistant coating, fitting for eyeglasses (lenses and frames).<br>Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |
| <b>MENTAL HEALTH SERVICES</b>                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Inpatient</b><br>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.<br>190 day lifetime limit in a psychiatric facility. | <b>0%</b> of the cost per stay                                                                                                                                                                                                                                                                                                    | <b>0%</b> of the cost per stay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Partial Hospitalization</b>                                                                                                                                                                                                                                                                                      | <b>10%</b> of the cost                                                                                                                                                                                                                                                                                                            | <b>10%</b> of the cost                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Intensive Outpatient Services</b>                                                                                                                                                                                                                                                                                | <b>10%</b> of the cost                                                                                                                                                                                                                                                                                                            | <b>10%</b> of the cost                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Outpatient group and individual therapy visits</b> <ul style="list-style-type: none"> <li>Primary care provider (PCP)</li> <li>Specialist's office</li> <li>Urgent care</li> <li>Outpatient Hospital</li> </ul>                                                                                                  | <b>0%</b> of the cost<br><b>10%</b> of the cost<br><b>\$50</b> copay<br><b>10%</b> of the cost                                                                                                                                                                                                                                    | <b>0%</b> of the cost<br><b>10%</b> of the cost<br><b>\$50</b> copay<br><b>10%</b> 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://www.humana.com/PAL).



## Covered Medical Benefits

|                                                                                                    | IN-NETWORK                                                                                                                                                                                                                                                                                                | OUT-OF-NETWORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>SKILLED NURSING FACILITY (SNF)</b>                                                              |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| This plan covers up to 100 days in a SNF.                                                          | <b>0%</b> of the cost per stay for days 1-20<br><b>10%</b> of the cost per stay for days 21-100                                                                                                                                                                                                           | <b>0%</b> of the cost per stay for days 1-20<br><b>10%</b> of the cost per stay for days 21-100                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| No 3-day hospital stay is required.<br>Plan pays \$0 after 100 days.                               |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>AMBULANCE</b>                                                                                   |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Per date of service regardless of the number of trips. Limited to Medicare-covered transportation. | <b>10%</b> of the cost                                                                                                                                                                                                                                                                                    | <b>10%</b> of the cost                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>TRANSPORTATION</b>                                                                              |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Uniformity Flexibility<br/>Non-Emergency Medical<br/>Transportation</b>                         | <b>\$0</b> 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.<br>This benefit is not to exceed 50 miles per trip. | <b>95%</b> coinsurance for plan approved location by car, rideshare services, van, wheelchair access vehicle for members with a Chronic Kidney Disease (CKD), End Stage Renal Disease (ESRD), or Cancer Diagnosis.<br>This benefit is not to exceed 50 miles per trip.<br>Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to 5% of the allowed amount on eligible items/services.<br>Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |
| <b>MEDICARE PART B PRESCRIPTION DRUGS</b>                                                          |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Chemotherapy drugs</b>                                                                          |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| • Specialist's office                                                                              | <b>10%</b> of the cost                                                                                                                                                                                                                                                                                    | <b>10%</b> of the cost                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| • Outpatient Hospital                                                                              | <b>10%</b> of the cost                                                                                                                                                                                                                                                                                    | <b>10%</b> of the cost                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Medicare Part B covered drugs</b>                                                               |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| • Primary care provider (PCP)                                                                      | <b>0%</b> of the cost                                                                                                                                                                                                                                                                                     | <b>0%</b> of the cost                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

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## Covered Medical Benefits

|                                                                                                                                                                                         | IN-NETWORK                                                                                                                         | OUT-OF-NETWORK                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Specialist's office</li> <li>Outpatient Hospital</li> <li>Pharmacy</li> </ul>                                                                    | <b>10%</b> of the cost<br><b>10%</b> of the cost<br><b>0%</b> of the cost                                                          | <b>10%</b> of the cost<br><b>10%</b> of the cost<br><b>0%</b> of the cost                                                                                                                                                                           |
| <b>Medicare Part B insulin drugs</b>                                                                                                                                                    |                                                                                                                                    |                                                                                                                                                                                                                                                     |
| <ul style="list-style-type: none"> <li>Primary care provider (PCP)</li> <li>Specialist's office</li> <li>Outpatient Hospital</li> <li>Pharmacy</li> </ul>                               | <b>0%</b> of the cost<br><b>10%</b> of the cost<br><b>10%</b> of the cost<br><b>0%</b> of the cost                                 | <b>0%</b> of the cost<br><b>10%</b> of the cost<br><b>10%</b> of the cost<br><b>0%</b> 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. |                                                                                                                                    |                                                                                                                                                                                                                                                     |
| <b>ACUPUNCTURE SERVICES</b>                                                                                                                                                             |                                                                                                                                    |                                                                                                                                                                                                                                                     |
| <b>Medicare-covered acupuncture visit(s) for chronic low back pain</b>                                                                                                                  | <b>10%</b> of the cost for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year. | <b>10%</b> of the cost 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. |
| <b>ALLERGY</b>                                                                                                                                                                          |                                                                                                                                    |                                                                                                                                                                                                                                                     |
| <b>Allergy shots &amp; serum</b>                                                                                                                                                        |                                                                                                                                    |                                                                                                                                                                                                                                                     |
| <ul style="list-style-type: none"> <li>Primary care provider (PCP)</li> <li>Specialist's office</li> </ul>                                                                              | <b>0%</b> of the cost<br><b>10%</b> of the cost                                                                                    | <b>0%</b> of the cost<br><b>10%</b> of the cost                                                                                                                                                                                                     |
| <b>CHIROPRACTIC SERVICES</b>                                                                                                                                                            |                                                                                                                                    |                                                                                                                                                                                                                                                     |
| <b>Medicare-covered chiropractic visit(s)</b>                                                                                                                                           | <b>10%</b> of the cost                                                                                                             | <b>10%</b> of the cost                                                                                                                                                                                                                              |
| <b>DIABETES SERVICES AND SUPPLIES</b>                                                                                                                                                   |                                                                                                                                    |                                                                                                                                                                                                                                                     |
| <b>Continuous glucose monitor (CGM)</b>                                                                                                                                                 |                                                                                                                                    |                                                                                                                                                                                                                                                     |
| <ul style="list-style-type: none"> <li>Durable medical equipment provider</li> <li>Pharmacy</li> <li>Preferred Pharmacy</li> </ul>                                                      | <b>10%</b> of the cost<br><b>10%</b> of the cost<br><b>\$0</b> copay                                                               | <b>10%</b> of the cost<br><b>10%</b> of the cost<br>Not Covered                                                                                                                                                                                     |
| <b>Diabetes management training</b>                                                                                                                                                     |                                                                                                                                    |                                                                                                                                                                                                                                                     |
| <ul style="list-style-type: none"> <li>Primary care provider (PCP)</li> <li>Specialist's office</li> <li>Outpatient hospital</li> </ul>                                                 | <b>0%</b> of the cost<br><b>0%</b> of the cost<br><b>0%</b> of the cost                                                            | <b>0%</b> of the cost<br><b>0%</b> of the cost<br><b>0%</b> 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://www.humana.com/PAL).



## Covered Medical Benefits

|                                                                                                                                   | IN-NETWORK      | OUT-OF-NETWORK  |
|-----------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------|
| <b>Diabetes monitoring supplies</b>                                                                                               |                 |                 |
| • 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     |
| <b>Diabetes screening</b>                                                                                                         |                 |                 |
| • Primary care provider (PCP)                                                                                                     | 0% of the cost  | 0% of the cost  |
| • Specialist's office                                                                                                             | 0% of the cost  | 0% of the cost  |
| <b>FOOT CARE (PODIATRY)</b>                                                                                                       |                 |                 |
| <b>Medicare-covered foot care</b>                                                                                                 | 10% of the cost | 10% of the cost |
| <b>HOME HEALTH CARE</b>                                                                                                           |                 |                 |
|                                                                                                                                   | 0% of the cost  | 0% of the cost  |
| <b>HOSPICE</b><br>You must get care from a Medicare-certified hospice. You must consult with this plan before you select hospice. |                 |                 |
| <b>MEDICAL EQUIPMENT/SUPPLIES</b>                                                                                                 |                 |                 |
| <b>Durable medical equipment</b>                                                                                                  |                 |                 |
| • Durable medical equipment provider                                                                                              | 10% of the cost | 10% of the cost |
| • Pharmacy                                                                                                                        | 10% of the cost | 10% of the cost |
| <b>Medical supplies (includes but not limited to: catheters, IV set-up and supplies)</b>                                          |                 |                 |
| • Medical supply provider                                                                                                         | 10% of the cost | 10% of the cost |
| • Pharmacy                                                                                                                        | 10% of the cost | 10% of the cost |
| <b>Prosthetics (artificial limbs or braces)</b>                                                                                   |                 |                 |
| • Prosthetics provider                                                                                                            | 10% of the cost | 10% of the cost |
| <b>OUTPATIENT SUBSTANCE ABUSE</b>                                                                                                 |                 |                 |
| <b>Outpatient group and individual substance abuse treatment visits</b>                                                           |                 |                 |
| • Primary care provider (PCP)                                                                                                     | 0% of the cost  | 0% of the cost  |
| • Specialist's office                                                                                                             | 10% of the cost | 10% of the cost |
| • Urgent care                                                                                                                     | \$50 copay      | \$50 copay      |
| • Outpatient hospital                                                                                                             | 10% of the cost | 10% 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://www.humana.com/PAL).



# Covered Medical Benefits

|                                           | IN-NETWORK      | OUT-OF-NETWORK  |
|-------------------------------------------|-----------------|-----------------|
| <b>REHABILITATION SERVICES</b>            |                 |                 |
| <b>Audiology Therapy</b>                  |                 |                 |
| • Specialist's office                     | 10% of the cost | 10% of the cost |
| • Comprehensive outpatient rehab facility | 10% of the cost | 10% of the cost |
| • Outpatient hospital                     | 10% of the cost | 10% of the cost |
| <b>Cardiac rehabilitation</b>             |                 |                 |
| • Specialist's office                     | 10% of the cost | 10% of the cost |
| • Outpatient hospital                     | 10% of the cost | 10% of the cost |
| <b>Occupational therapy</b>               |                 |                 |
| • Specialist's office                     | 10% of the cost | 10% of the cost |
| • Comprehensive outpatient rehab facility | 10% of the cost | 10% of the cost |
| • Outpatient hospital                     | 10% of the cost | 10% of the cost |
| <b>Physical therapy</b>                   |                 |                 |
| • Specialist's office                     | 10% of the cost | 10% of the cost |
| • Comprehensive outpatient rehab facility | 10% of the cost | 10% of the cost |
| • Outpatient hospital                     | 10% of the cost | 10% of the cost |
| <b>Pulmonary rehabilitation</b>           |                 |                 |
| • Specialist's office                     | 10% of the cost | 10% of the cost |
| • Comprehensive outpatient rehab facility | 10% of the cost | 10% of the cost |
| • Outpatient hospital                     | 10% of the cost | 10% of the cost |
| <b>Speech therapy</b>                     |                 |                 |
| • Specialist's office                     | 10% of the cost | 10% of the cost |
| • Comprehensive outpatient rehab facility | 10% of the cost | 10% of the cost |
| • Outpatient hospital                     | 10% of the cost | 10% of the cost |
| <b>RENAL DIALYSIS</b>                     |                 |                 |
| <b>Renal dialysis services</b>            |                 |                 |
| • Dialysis center                         | 10% of the cost | 10% of the cost |
| • Outpatient hospital                     | 10% of the cost | 10% of the cost |
| <b>Kidney disease education services</b>  |                 |                 |
| • 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  |

**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://www.humana.com/PAL).



## Covered Medical Benefits

|                                                                                             | IN-NETWORK             | OUT-OF-NETWORK |
|---------------------------------------------------------------------------------------------|------------------------|----------------|
| <b>HUMANA IN-NETWORK TELEHEALTH VENDORS, i.e. MDLive (in addition to Original Medicare)</b> |                        |                |
| <b>Primary care provider (PCP)</b>                                                          | <b>\$0</b> copay       | Not Covered    |
| <b>Specialist</b>                                                                           | <b>10%</b> of the cost | Not Covered    |
| <b>Urgent care services</b>                                                                 | <b>\$0</b> copay       | Not Covered    |
| <b>Substance abuse or behavioral health services</b>                                        | <b>\$0</b> copay       | Not Covered    |

**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://www.humana.com/PAL).



## Additional Benefits

|                                                                                                                                                                                                                                                                                                            | IN-NETWORK       | OUT-OF-NETWORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>FITNESS AND WELLNESS</b>                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Live a healthier, more active life through fitness and social connection at participating SilverSneakers® locations and online.                                                                                                                                                                            | <b>\$0</b> copay | <b>95%</b> coinsurance for out-of-network fitness centers. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to 5% of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |
| <b>HEALTH EDUCATION SERVICES</b>                                                                                                                                                                                                                                                                           |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 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. | <b>\$0</b> copay | Not Applicable                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

**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://www.humana.com/PAL).



## Additional Benefits

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | IN-NETWORK                                                                                      | OUT-OF-NETWORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>POST-DISCHARGE SERVICES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <ul style="list-style-type: none"><li>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.</li><li>2 meals per day for 14 days, up to 28 meals delivered to your door.</li><li>Transportation up to 12 one-way trips to plan approved locations by rideshare services, car, van or wheelchair accessible vehicle.</li><li>In-network services must be scheduled by approved vendors, scheduled within 30 days of discharge event and utilized within 60 days of discharge.</li></ul> | <b>\$0</b> copay per discharge event following each inpatient or skilled nursing facility stay. | <b>95%</b> coinsurance for out-of-network post-discharge services. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to 5% of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |
| <b>SMOKING CESSATION (ADDITIONAL)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>\$0</b> copay                                                                                | Not Applicable                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

**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://www.humana.com/PAL).



## Additional Benefits

### IN-NETWORK

### OUT-OF-NETWORK

#### UNIFORMITY FLEXIBILITY VIRTUAL CARDIAC RECOVERY

Delivered via telehealth, virtual cardiac recovery program provides up to 36 covered sessions to support recovery and reduce the risk of hospital readmission.

**\$0** copay

**95%** coinsurance for cardiac recovery services provided via telehealth under virtual supervision by a physician or qualified practitioner. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to 5% of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

**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://www.humana.com/PAL).

## 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.

## 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.

[illegible]

# 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)**.

አማርኛ [Amharic]: ነፃ ቋንቋ፣ አጋዥ ማዳመጫ፣ እና አማራጭ ቅርፅ ያላቸው አገልግሎቶችም ይገኛሉ። በ

**877-320-1235 (TTY: 711)** ላይ ይደውሉ።

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

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

Bàsà [Bassa]: Wuḍu-xwíniín-mú-zà-zà kùà, hwòdǒ-fónó-nyò,, kè nyo-bǒ-po-kà bě bě wa nyuésé wíqí péré-pérédò kò. Ðá **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]: Gen sèvis lengwistik gratis, èd oksilyè, ak lòt fòm sèvis ki disponib. Rele **877-320-1235 (TTY: 711)**.

Hrvatski [Croatian]: Dostupne su besplatne jezične usluge, usluge dodatne pomoći i 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 d'assistance linguistique, d'aide auxiliaire et de format alternatif sont disponibles. Appelez le **877-320-1235 (ATS : 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]: મફત 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)**

हिंदी [Hindi]: निःशुल्क 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)**.

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

GHHNOA2026HUM\_0526

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

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 សេវាកម្មជាន់មុខផ្សេងៗសម្រាប់អ្នកប្រើប្រាស់។ 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]: ມີບໍລິການພາສາ, ອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ຮູບແບບທາງເລືອກອື່ນໆສ່ວຍຄ່າໃຫ້. ໂທ **877-320-1235 (TTY: 711)**.

Diné [Navajo]: Saad bee áná'álwo', bee haz'áanii, dóó naaltsoos t'áá ajilíí'ígíí bee ak'e'elyaaígíí t'áá jik'eh hólǫ́. **877-320-1235 (TTY: 711)** bich'í' hodíílnih.

नेपाली [Nepali]: निःशुल्क भाषा सेवा, सहायक सामग्री र वैकल्पिक ढाँचाका सेवाहरू उपलब्ध छन् । **877-320-1235 (TTY: 711)** मा कल गर्नुहोस् ।

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

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

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਾਮਾਨ, ਅਤੇ ਵਿਕਲਪਿਕ ਢਾਂਚੇ 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 serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **877-320-1235 (TTY: 711)**.

தமிழ் [Tamil]: மொழி,, உதவிப் பொருட்கள் மற்றும் மாற்று வடிவமைப்புச் சேவைகள் இலவசமாகக் கிடைக்கின்றன. **877-320-1235 (TTY: 711)** எண்ணை 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 [Urdu]: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال

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

Òyìnbó [Yoruba]: Àwọn isẹ̀ àtìlẹ́hìn ìrànlowọ̀ èdè, àtì ọ̀nà kíkà mírán wà lárọ̀wótó lófẹ̀ẹ̀. Pe **877-320-1235 (TTY: 711)**.



## Find out **more**

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You can see this plan's provider directory at **<https://your.Humana.com/ctarhct>** or call us at the number listed at the beginning of this booklet and we will send you one.

Humana is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

If you want to compare this plan with other Medicare health plans, you can call your employer or union sponsoring this plan to find out if you have other options through them.

If you want to know more about the coverage and costs of Original Medicare, look in your 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, 7 days a week. TTY users should call 1-877-486-2048.

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<https://your.Humana.com/ctarhct>

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