2026

# Summary of Benefits

**Humana Group Medicare Advantage PPO Plan**
**PPO 079/699**

**International Association of Machinists & Aerospace Workers**

Humana®

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

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

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

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, refer to the "Evidence of Coverage."

## To be eligible

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

## Plan name:

Humana Group Medicare Advantage PPO plan

## How to reach us:

Members should call toll-free **1-800-733-9064** for questions **(TTY/TDD: 711)**

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

Or visit our website: **https://your.Humana.com/iamaw**

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.

## A healthy partnership

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

# Monthly Premium, Deductible and Limits

| PLAN COSTS | |
|---|---|
| **Monthly premium**<br>You must keep paying your Medicare Part B premium. | For information concerning the actual premiums you will pay, please contact Humana. |
| **Medical deductible** | This plan does not have a deductible. |
| **Medical Maximum out-of-pocket responsibility**<br>The most you pay for copays, coinsurance and other costs for medical services for the year. | **In-Network Maximum Out-of-Pocket**<br>**$4,750** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; Dental Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Uniform Flexibility Non-Emergency Medical Transportation; Vision Services (Routine) and the Plan Premium do not apply to the in-network maximum out-of-pocket.<br><br>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.<br><br>**Combined In and Out-of-Network Maximum Out-of-Pocket**<br>**$4,750** out-of-pocket limit for Medicare-covered services.<br>In-Network Exclusions: Part D Pharmacy; Dental Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Uniform Flexibility Non-Emergency Medical Transportation; Vision Services (Routine) and the Plan Premium do not apply to the combined maximum out-of-pocket.<br>Out-of-Network Exclusions: Part D Pharmacy, Dental Services (Routine); Hearing Services (Routine); Vision Services (Routine); Worldwide Coverage and the Plan Premium do not apply to the combined maximum out-of-pocket.<br><br>Your limit for services received from in-network providers will count toward this limit.<br><br>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.*

# Covered Medical Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **ACUTE INPATIENT HOSPITAL CARE** | | |
| This plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. | **$195** copay per day for days 1-5 | **$195** copay per day for days 1-5 |
| **OUTPATIENT HOSPITAL COVERAGE** | | |
| **Diagnostic colonoscopy** | **$245** copay | **$245** copay |
| **Diagnostic mammography** | **$90** copay | **$90** copay |
| **Observation services** | **$0** copay | **$0** copay |
| **Surgery services** | **$245** copay | **$245** copay |
| **AMBULATORY SURGICAL CENTER** | | |
| **Diagnostic colonoscopy** | **$220** copay | **$220** copay |
| **Surgery services** | **$220** copay | **$220** copay |
| **DOCTOR OFFICE VISITS** | | |
| **Primary care provider (PCP)** | **$0** copay | **$0** copay |
| **Specialists** | **$35** copay | **$35** copay |

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# Covered Medical Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **PREVENTIVE CARE** | | |
| This plan covers all Medicare preventative services including:<br>• Abdominal aortic aneurysm screening<br>• Alcohol misuse screening & counseling<br>• Annual wellness visit<br>• Bone mass measurement<br>• Breast cancer screening<br>• Cardiovascular disease behavioral therapy<br>• Cardiovascular disease screening<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screening<br>• Depression screening<br>• Diabetes self-management training<br>• Diabetes screening<br>• Glaucoma screening<br>• Hepatitis C screening<br>• HIV screening<br>• Kidney disease education services<br>• Lung cancer screening<br>• Medical nutrition therapy<br>• Obesity screening and therapy<br>• Physical exams (routine)<br>• Prostate cancer screening exam<br>• Smoking and tobacco use cessation<br>• STI screening and counseling<br>• "Welcome to Medicare" preventative visit | **Covered at no cost** | **Covered at no cost** |
| • Immunizations<br>• Medicare diabetes prevention program (MDPP)<br><br>Any additional preventative services approved by Medicare during the contract year will be covered. | **Covered at no cost** | **Covered at no cost** |

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# Covered Medical Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **EMERGENCY CARE** | | |
| **Emergency room**<br>If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. | **$110** copay for Medicare-covered emergency room visit(s) | **$110** copay for Medicare-covered emergency room visit(s) |
| **Urgently needed services** | | |
| • Primary care provider (PCP) | **$0** copay | **$0** copay |
| • Specialist's office | **$35** copay | **$35** copay |
| • Urgent care center | **$45** copay | **$45** copay |
| Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. | | |
| **DIAGNOSTIC SERVICES, LABS AND IMAGING** | | |
| **Advanced imaging services (MRI, MRA, PET and CT Scan)** | | |
| • Primary care provider (PCP) | **$0** copay | **$0** copay |
| • Specialist's office | **$45** copay | **$45** copay |
| • Freestanding radiological facility | **$180** copay | **$180** copay |
| • Outpatient Hospital | **$245** copay | **$245** copay |
| **Diagnostic mammography** | | |
| • Primary care provider (PCP) | **$0** copay | **$0** copay |
| • Specialist's office | **$30** copay | **$30** copay |
| • Freestanding radiological facility | **$45** copay | **$45** copay |
| • Outpatient Hospital | **$90** copay | **$90** copay |
| **Diagnostic procedures and tests** | | |
| • Primary care provider (PCP) | **$0** copay | **$0** copay |
| • Specialist's office | **$35** copay | **$35** copay |
| • Urgent care center | **$45** copay | **$45** copay |
| • Freestanding radiological facility | **$45** copay | **$45** copay |
| • Outpatient Hospital | **$90** copay | **$90** copay |
| **EKG screening** | | |
| • Primary care provider (PCP) | **$0** copay | **$0** copay |
| • Specialist's office | **$0** copay | **$0** copay |

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# Covered Medical Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| • Freestanding radiological facility | **$0** copay | **$0** copay |
| • Outpatient Hospital | **$0** copay | **$0** copay |
| **Lab services** | | |
| • Primary care provider (PCP) | **$0** copay | **$0** copay |
| • Specialist's office | **$0** copay | **$0** copay |
| • Urgent care center | **$0** copay | **$0** copay |
| • Freestanding laboratory | **$0** copay | **$0** copay |
| • Outpatient Hospital | **$45** copay | **$45** copay |
| **Nuclear medicine services** | | |
| • Freestanding radiological facility | **$90** copay | **$90** copay |
| • Outpatient Hospital | **$245** copay | **$245** copay |
| **Outpatient x-rays** | | |
| • Primary care provider (PCP) | **$0** copay | **$0** copay |
| • Specialist's office | **$35** copay | **$35** copay |
| • Urgent care center | **$45** copay | **$45** copay |
| • Freestanding radiological facility | **$45** copay | **$45** copay |
| • Outpatient Hospital | **$90** copay | **$90** copay |
| **Radiation therapy** | | |
| • Specialist's office | **$35** copay | **$35** copay |
| • Freestanding radiological facility | **20%** of the cost | **20%** of the cost |
| • Outpatient Hospital | **20%** of the cost | **20%** of the cost |
| **HEARING SERVICES** | | |
| **Medicare-covered hearing: diagnostic hearing and balance exams** | **$35** copay | **$35** copay |
| **Routine hearing**<br><br>TruHearing Provider must be used. Contact Customer Service to locate a provider. | **$0** copay for routine hearing exams up to 1 per year.<br>**$500** maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year.<br>Note: Includes 80 batteries per aid and 3 year warranty. | The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges. |
| **DENTAL SERVICES** | | |
| **Medicare-covered dental** | **$35** copay | **$35** copay |
| **Routine dental** | | |

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| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| | **0%** of the cost for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.<br>**0%** of the cost for panoramic film or diagnostic x-rays up to 1 every 5 years.<br>**0%** of the cost for bitewing x-rays up to 1 set(s) per year.<br>**0%** of the cost for emergency diagnostic exam, intraoral x-rays up to 1 per year.<br>**0%** of the cost for amalgam and/or composite filling, fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year.<br>**0%** of the cost for periodontal maintenance up to 4 per year.<br>**0%** of the cost for simple or surgical extraction up to unlimited per year.<br>**0%** of the cost for necessary anesthesia (inhalation of nitrous oxide/analgesia, anxiolysis) with covered service up to as needed with covered codes per year.<br>**$500** combined maximum benefit coverage amount per year for all preventive and comprehensive benefits. | **0%** of the cost for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.<br>**0%** of the cost for panoramic film or diagnostic x-rays up to 1 every 5 years.<br>**0%** of the cost for bitewing x-rays up to 1 set(s) per year.<br>**0%** of the cost for emergency diagnostic exam, intraoral x-rays up to 1 per year.<br>**0%** of the cost for amalgam and/or composite filling, fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year.<br>**0%** of the cost for periodontal maintenance up to 4 per year.<br>**0%** of the cost for simple or surgical extraction up to unlimited per year.<br>**0%** of the cost for necessary anesthesia (inhalation of nitrous oxide/analgesia, anxiolysis) with covered service up to as needed with covered codes per year.<br>**$500** combined maximum benefit coverage amount per year for all preventive and comprehensive benefits.<br>Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |

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

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

***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.*

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|

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

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

| **VISION SERVICES** | | |
|---|---|---|
| **Medicare-covered vision services** | **$35** copay | **$35** copay |
| **Medicare-covered diabetic eye exam (1 per year)** | **$0** copay | **$0** copay |
| **Medicare-covered glaucoma screening (1 per year)** | **$0** copay | **$0** copay |
| **Medicare-covered eyewear (post-cataract)** | **$35** copay | **$35** copay |
| **Routine vision**<br><br>EyeMed is the In-Network provider for the routine vision benefit. Contact Customer Service to locate a provider. | **$0** copay for routine exam (includes refraction) up to 1 per year.<br>**$100** 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). | **$175** combined maximum benefit coverage amount per year for routine exam (includes refraction).<br>**$0** copay for routine exam (includes refraction) up to 1 per year.<br>**$100** 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. |

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# Covered Medical Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **MENTAL HEALTH SERVICES** | | |
| **Inpatient**<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. | **$195** copay per day for days 1-5 | **$195** copay per day for days 1-5 |
| **Partial Hospitalization** | **$55** copay | **$55** copay |
| **Intensive Outpatient Services** | **$55** copay | **$55** copay |
| **Outpatient group and individual therapy visits** | | |
| • Primary care provider (PCP) | **$0** copay | **$0** copay |
| • Specialist's office | **$35** copay | **$35** copay |
| • Urgent care | **$45** copay | **$45** copay |
| • Outpatient Hospital | **$35** copay | **$35** copay |
| **SKILLED NURSING FACILITY** | | |
| This plan covers up to 100 days in a SNF.<br><br>No 3-day hospital stay is required.<br>Plan pays $0 after 100 days. | **$0** copay per day for days 1-20<br>**$196** copay per day for days 21-100 | **$0** copay per day for days 1-20<br>**$196** copay per day for days 21-100 |
| **AMBULANCE** | | |
| Per date of service regardless of the number of trips. Limited to Medicare-covered transportation. | **$265** copay | **$265** copay |

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# Covered Medical Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **TRANSPORTATION** | | |
| **Uniform Flexibility Non-Emergency Medical Transportation** | **$0** copay for plan approved location up to unlimited one-way trip(s) per year by car, rideshare services, van, wheelchair access vehicle for members with a Chronic Kidney Disease (CKD), End Stage Renal Disease (ESRD), or Cancer Diagnosis.<br>This benefit is not to exceed 50 miles per trip. | The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges. |
| **MEDICARE PART B PRESCRIPTION DRUGS** | | |
| **Chemotherapy drugs** | | |
| • Specialist's office | **20%** of the cost | **20%** of the cost |
| • Outpatient Hospital | **20%** of the cost | **20%** of the cost |
| **Medicare Part B covered drugs** | | |
| • Primary care provider (PCP) | **$0** copay | **$0** copay |
| • Specialist's office | **$0** copay | **$0** copay |
| • Outpatient Hospital | **$0** copay | **$0** copay |
| • Pharmacy | **20%** of the cost | **20%** of the cost |
| **Medicare Part B insulin drugs** | | |
| • Primary care provider (PCP) | **$0** copay | **$0** copay |
| • Specialist's office | **$0** copay | **$0** copay |
| • Outpatient Hospital | **$0** copay | **$0** copay |
| • Pharmacy | **20%** of the cost | **20%** 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. | | |
| **ACUPUNCTURE SERVICES** | | |
| **Medicare-covered acupuncture visit(s) for chronic low back pain** | **$35** copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year. | **$35** copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year.<br>Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |

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# Covered Medical Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **ALLERGY** | | |
| **Allergy shots & serum** | | |
| • Primary care provider (PCP) | **$0** copay | **$0** copay |
| • Specialist's office | **$35** copay | **$35** copay |
| **CHIROPRACTIC SERVICES** | | |
| **Medicare-covered chiropractic visit(s)** | **$15** copay | **$15** copay |
| **DIABETES SERVICES AND SUPPLIES** | | |
| **Continuous glucose monitor (CGM)** | | |
| • Durable medical equipment provider | **20%** of the cost | **20%** of the cost |
| • Pharmacy | **20%** of the cost | **20%** of the cost |
| **Diabetes management training** | | |
| • Primary care provider (PCP) | **$0** copay | **$0** copay |
| • Specialist's office | **$0** copay | **$0** copay |
| • Outpatient hospital | **$0** copay | **$0** copay |
| **Diabetes monitoring supplies** | | |
| • Durable medical equipment provider | **20%** of the cost | **20%** of the cost |
| • Pharmacy | **20%** of the cost | **20%** of the cost |
| • Preferred diabetic supplier | **$0** copay | Not Covered |
| **Diabetes screening** | | |
| • Primary care provider (PCP) | **$0** copay | **$0** copay |
| • Specialist's office | **$0** copay | **$0** copay |
| **FOOT CARE (PODIATRY)** | | |
| **Medicare-covered foot care** | **$35** copay | **$35** copay |
| **HOME HEALTH CARE** | | |
| | **$0** copay | **$0** copay |
| **HOSPICE**<br>You must get care from a Medicare-certified hospice. You must consult with this plan before you select hospice. | | |
| **MEDICAL EQUIPMENT/SUPPLIES** | | |
| **Durable medical equipment** | | |
| • Durable medical equipment provider | **20%** of the cost | **20%** of the cost |
| • Pharmacy | **20%** of the cost | **20%** of the cost |

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# Covered Medical Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Medical supplies (includes but not limited to: catheters, IV set-up and supplies)** | | |
| • Medical supply provider | **20%** of the cost | **20%** of the cost |
| • Pharmacy | **20%** of the cost | **20%** of the cost |
| **Prosthetics (artificial limbs or braces)** | | |
| • Prosthetics provider | **20%** of the cost | **20%** of the cost |
| **OUTPATIENT SUBSTANCE ABUSE** | | |
| **Outpatient group and individual substance abuse treatment visits** | | |
| • Primary care provider (PCP) | **$0** copay | **$0** copay |
| • Specialist's office | **$35** copay | **$35** copay |
| • Urgent care | **$45** copay | **$45** copay |
| • Outpatient hospital | **$35** copay | **$35** copay |
| **REHABILITATION SERVICES** | | |
| **Audiology Therapy** | | |
| • Specialist's office | **$35** copay | **$35** copay |
| • Comprehensive outpatient rehab facility | **$35** copay | **$35** copay |
| • Outpatient hospital | **$40** copay | **$40** copay |
| **Cardiac rehabilitation** | | |
| • Specialist's office | **$35** copay | **$35** copay |
| • Outpatient hospital | **$35** copay | **$35** copay |
| **Occupational therapy** | | |
| • Specialist's office | **$35** copay | **$35** copay |
| • Comprehensive outpatient rehab facility | **$35** copay | **$35** copay |
| • Outpatient hospital | **$40** copay | **$40** copay |
| **Physical therapy** | | |
| • Specialist's office | **$35** copay | **$35** copay |
| • Comprehensive outpatient rehab facility | **$35** copay | **$35** copay |
| • Outpatient hospital | **$40** copay | **$40** copay |
| **Pulmonary rehabilitation** | | |
| • Specialist's office | **$15** copay | **$15** copay |
| • Comprehensive outpatient rehab facility | **$15** copay | **$15** copay |
| • Outpatient hospital | **$15** copay | **$15** copay |

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# Covered Medical Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Speech therapy** | | |
| • Specialist's office | **$35** copay | **$35** copay |
| • Comprehensive outpatient rehab facility | **$35** copay | **$35** copay |
| • Outpatient hospital | **$40** copay | **$40** copay |
| **RENAL DIALYSIS** | | |
| **Renal dialysis services** | | |
| • Dialysis center | **20%** of the cost | **20%** of the cost |
| • Outpatient hospital | **20%** of the cost | **20%** of the cost |
| **Kidney disease education services** | | |
| • Primary care provider (PCP) | **$0** copay | **$0** copay |
| • Specialist's office | **$0** copay | **$0** copay |
| • Outpatient hospital | **$0** copay | **$0** copay |
| **HUMANA IN-NETWORK TELEHEALTH VENDORS, i.e. MDLive (in addition to Original Medicare)** | | |
| **Primary care provider (PCP)** | **$0** copay | Not Covered |
| **Specialist** | **$35** copay | Not Covered |
| **Urgent care services** | **$0** copay | Not Covered |
| **Substance abuse or behavioral health services** | **$0** copay | Not Covered |

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# Additional Benefits

| | |
|---|---|
| **FITNESS AND WELLNESS** | |
| | Live a healthier, more active life through fitness and social connection at participating SilverSneakers® locations and online.<br><br>The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges. |
| **HEALTH EDUCATION SERVICES** | |
| | Personal Health Coaching is an interactive inbound and outreach on-line and telephonic wellness coaching for Medicare participants who elect to participate, for wellness improvement, including weight management, nutrition, exercise, back care, blood pressure management, and blood sugar management.<br><br>The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges. |
| **POST-DISCHARGE SERVICES** | |
| | **$0** copay for the following benefits per discharge event following each inpatient or skilled nursing facility stay:<br>• 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.<br>• 2 meals per day for 14 days, up to 28 meals delivered to your door.<br>• Transportation to plan approved locations by rideshare services, car, van or wheelchair accessible vehicle.<br>Services must be provided by approved vendors, scheduled within 30 days of discharge event and utilized within 60 days of discharge.<br><br>The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges. |
| **SMOKING CESSATION (ADDITIONAL)** | |
| | A comprehensive smoking cessation program available online, email and phone. Personal coaches assist via establishing goals and providing articles and resources to aid in the effort to quit smoking.<br><br>The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges. |

***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.*

# Notes

# Notice of Availability - Auxiliary Aids and Services Notice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

हिन्दी [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)**.

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

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

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

ភាសាខ្មែរ [Khmer]៖ សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ ទូរសព្ទទៅ លេខ **877-320-1235 (TTY: 711)**។

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

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

Diné [Navajo]: Saad t’áá jiik’eh, t’áadoole’é binahjį’ bee adahodooníłígíí diné bich’į’ anídahazt’i’í, dóó łahgo át’éego bee hada’dilyaaígíí bee bika’aanída’awo’í dahólǫ. Kohjį’ hodíilnih **877-320-1235 (TTY: 711)**.

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

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

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

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

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

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

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

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

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

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

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

Bǎsɔ́ ̀[Bassa]: Wuɖu-xwíníín-mú-zà-zà kǔà, Hwòɖǒ-fɔńɔ-́nyɔ,́ kè nyɔ-bɔǔn-po-kà ɓě ɓé nyuɛɛ se wíɖí pɛ́ɛ̀-pɛ́ɛ̀ ɖò kɔ.̀ **877-320-1235 (TTY: 711)** ɖá.

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

Òyìnbó [Yoruba]: Àwọn iṣẹ́ àtìlẹhìn ìrànlọ́wọ́ èdè, àti ọ̀nà kíkà míràn wà lárọwọ́tó. Pe **877-320-1235 (TTY: 711)**.

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

# Find out **more**

You can see this plan's provider directory at **https://your.Humana.com/iamaw** 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/iamaw

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