

2026

# Summary of Benefits

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PEEHIP Humana Group Medicare Advantage PPO Plan  
PPO 079/828

PEEHIP



**PEEHIP**

**Humana**®

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SB079828EN26

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



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

Find out more about the PEEHIP 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 PEEHIP 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:**

PEEHIP Humana Group Medicare Advantage PPO plan

## **How to reach us:**

Members should call toll-free  
**1-800-747-0008** for questions  
(TTY/TDD: 711)

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

Or visit our website:  
**[your.Humana.com/peehip](http://your.Humana.com/peehip)**

PEEHIP Humana Group Medicare Advantage PPO plan has a network of doctors, hospitals, and other providers. For more information, please call PEEHIP Humana Group Medicare Customer Care at **1-800-747-0008**.



## **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

You must keep paying your Medicare Part B premium. For information concerning your PEEHIP premium, please contact PEEHIP at **1-334-517-7000** or toll free at **1-877-517-0020**.

### Medical deductible

**\$257** per year for some combined in- and out-of-network services

### Medical Combined In and Out-of-Network Maximum out-of-pocket responsibility

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

**\$8,850** out-of-pocket limit for Medicare-covered services.

Combined In and Out-of-Network Exclusions: Part D Pharmacy; Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Personal Emergency Response System; 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.

Out-of-Network Exclusions: Part D Pharmacy, Hearing Services (Routine); Personal Emergency Response System; Vision Services (Routine); Worldwide Coverage and the Plan Premium do not apply to the combined maximum out-of-pocket.

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

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

**Note:** This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](http://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 day 1 <b>\$25</b> copay per day for days 2-5 <b>\$0</b> copay per day for days 6-365	<b>\$200</b> copay per day for day 1 <b>\$25</b> copay per day for days 2-5 <b>\$0</b> copay per day for days 6-365
<b>OUTPATIENT HOSPITAL COVERAGE</b>		
<b>Diagnostic colonoscopy</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>Diagnostic mammography</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>Observation services</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>Surgery services</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>AMBULATORY SURGICAL CENTER</b>		
<b>Diagnostic colonoscopy</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>Surgery services</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>DOCTOR OFFICE VISITS</b>		
<b>Primary care provider (PCP)</b>	<b>\$13</b> copay	<b>\$13</b> copay
<b>Specialists</b>	<b>\$18</b> copay	<b>\$18</b> copay

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# Covered Medical Benefits

## IN-NETWORK

## OUT-OF-NETWORK

### PREVENTIVE CARE

This plan covers all Medicare preventative services including:

- Abdominal aortic aneurysm screening
- Alcohol misuse screening & counseling
- Annual wellness visit
- Bone mass measurement
- Breast cancer screening
- Cardiovascular disease behavioral therapy
- Cardiovascular disease screening
- Cervical and vaginal cancer screening
- Colorectal cancer screening
- Depression screening
- Diabetes self-management training
- Diabetes screening
- Glaucoma screening
- Hepatitis C screening
- HIV screening
- Kidney disease education services
- Lung cancer screening
- Medical nutrition therapy
- Obesity screening and therapy
- Physical exams (routine)
- Prostate cancer screening exam
- Smoking and tobacco use cessation
- STI screening and counseling
- "Welcome to Medicare" preventative visit

**Covered at no cost**

**Covered at no cost**

- Immunizations
- Medicare diabetes prevention program (MDPP)

**Covered at no cost**

**Covered at no cost**

Any additional preventative services approved by Medicare during the contract year will be covered.

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# Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>EMERGENCY CARE</b>		
<b>Emergency room</b> 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.	<b>\$35</b> copay for Medicare-covered emergency room visit(s)	<b>\$35</b> copay for Medicare-covered emergency room visit(s)
<b>Urgently needed services</b> Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	<b>\$13</b> copay <b>\$18</b> copay <b>\$18</b> copay	<b>\$13</b> copay <b>\$18</b> copay <b>\$18</b> copay
<b>DIAGNOSTIC SERVICES, LABS AND IMAGING</b>		
<b>Advanced imaging services (MRI, MRA, PET and CT Scan)</b>		
• Primary care provider (PCP)	<b>\$0</b> copay	<b>\$0</b> copay
• Specialist's office	<b>\$0</b> copay	<b>\$0</b> copay
• Freestanding radiological facility	<b>\$0</b> copay	<b>\$0</b> copay
• Outpatient Hospital	<b>\$0</b> copay	<b>\$0</b> copay
<b>Diagnostic mammography</b>		
• Primary care provider (PCP)	<b>\$0</b> copay	<b>\$0</b> copay
• Specialist's office	<b>\$0</b> copay	<b>\$0</b> copay
• Freestanding radiological facility	<b>\$0</b> copay	<b>\$0</b> copay
• Outpatient Hospital	<b>\$0</b> copay	<b>\$0</b> copay
<b>Diagnostic procedures and tests</b>		
• Primary care provider (PCP)	<b>\$0</b> copay	<b>\$0</b> copay
• Specialist's office	<b>\$0</b> copay	<b>\$0</b> copay
• Urgent care center	<b>\$18</b> copay	<b>\$18</b> copay
• Freestanding radiological facility	<b>\$0</b> copay	<b>\$0</b> copay
• Outpatient Hospital	<b>\$0</b> copay	<b>\$0</b> copay
<b>EKG screening</b>		
• Primary care provider (PCP)	<b>\$0</b> copay	<b>\$0</b> copay
• Specialist's office	<b>\$0</b> copay	<b>\$0</b> copay

**Note:** This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](http://Humana.com/PAL).



## Covered Medical Benefits

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
• Freestanding radiological facility	<b>\$0</b> copay	<b>\$0</b> copay
• Outpatient Hospital	<b>\$0</b> copay	<b>\$0</b> copay
<b>Lab services</b>		
• Primary care provider (PCP)	<b>\$0</b> copay	<b>\$0</b> copay
• Specialist's office	<b>\$0</b> copay	<b>\$0</b> copay
• Urgent care center	<b>\$0</b> copay	<b>\$0</b> copay
• Freestanding laboratory	<b>\$0</b> copay	<b>\$0</b> copay
• Outpatient Hospital	<b>\$0</b> copay	<b>\$0</b> copay
<b>Nuclear medicine services</b>		
• Freestanding radiological facility	<b>\$0</b> copay	<b>\$0</b> copay
• Outpatient Hospital	<b>\$0</b> copay	<b>\$0</b> copay
<b>Outpatient x-rays</b>		
• Primary care provider (PCP)	<b>\$0</b> copay	<b>\$0</b> copay
• Specialist's office	<b>\$0</b> copay	<b>\$0</b> copay
• Urgent care center	<b>\$18</b> copay	<b>\$18</b> copay
• Freestanding radiological facility	<b>\$0</b> copay	<b>\$0</b> copay
• Outpatient Hospital	<b>\$0</b> copay	<b>\$0</b> copay
<b>Radiation therapy</b>		
• Specialist's office	<b>\$0</b> copay	<b>\$0</b> copay
• Freestanding radiological facility	<b>\$0</b> copay	<b>\$0</b> copay
• Outpatient Hospital	<b>\$0</b> copay	<b>\$0</b> copay
<b>HEARING SERVICES</b>		
<b>Medicare-covered hearing: diagnostic hearing and balance exams</b>	<b>\$18</b> copay	<b>\$18</b> copay

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# Covered Medical Benefits

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Routine hearing</b>  TruHearing Provider must be used. Contact PEEHIP Humana Group Medicare Customer Care team at <b>1-800-747-0008</b> to locate a provider.	<b>\$0</b> copayment for routine hearing exams up to 1 per year. <b>\$500</b> maximum benefit coverage amount for hearing aid(s) (all types) up to 2 every 3 years. Benefit includes prescription or over-the counter hearing aid(s). Note: Includes 80 batteries per aid and 3 year warranty.	<b>\$0</b> copayment for routine hearing exams up to 1 per year. <b>\$500</b> maximum benefit coverage amount for hearing aid(s) (all types) up to 2 every 3 years. Benefit includes prescription or over-the counter hearing aid(s). Note: Prior authorization is required to access out-of-network benefits depending on provider availability in service area. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. 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

<b>Medicare-covered dental</b>	<b>\$18</b> copay	<b>\$18</b> copay
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## VISION SERVICES

<b>Medicare-covered vision services</b>	<b>\$18</b> copay	<b>\$18</b> copay
<b>Medicare-covered diabetic eye exam (1 per year)</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>Medicare-covered glaucoma screening (1 per year)</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>Medicare-covered eyewear (post-cataract)</b>	<b>\$0</b> copay	<b>\$0</b> copay

**Note:** This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](http://Humana.com/PAL).



# Covered Medical Benefits

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Routine vision</b>  EyeMed is the In-Network provider for the routine vision benefit. Contact Customer Service to locate a provider.	<b>\$0</b> copay for routine exam (includes refraction) up to 1 per year.	<b>\$175</b> combined maximum benefit coverage amount per year for routine exam (includes refraction). <b>\$0</b> copay for routine exam (includes refraction) up to 1 per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges

## PERSONAL EMERGENCY RESPONSE SYSTEM

<b>Personal Emergency Response System (PERS)</b>	<b>\$0</b> copay for either an On The Go Mobile personal help button or an On the Go Mobility personal help button. Both function in and out of the home. On The Go uses two way voice communication & five location seeking technologies to send help quickly to wherever the member is located. On the Go Mobility mobile device offers fall detection remotely activated/deactivated, up to 5 days of battery life, location services, and wandering. Accommodation for Pacemakers and Implanted Devices when worn at the waist with free leather pouch and auto fall detection deactivated.	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges
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**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](http://Humana.com/PAL).



# Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>MENTAL HEALTH SERVICES</b>		
<b>Inpatient</b> 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.	<b>\$200</b> copay per day for day 1 <b>\$25</b> copay per day for days 2-5 <b>\$0</b> copay per day for days 6-365	<b>\$200</b> copay per day for day 1 <b>\$25</b> copay per day for days 2-5 <b>\$0</b> copay per day for days 6-365
<b>Partial Hospitalization</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>Intensive Outpatient Services</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>Outpatient 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>\$18</b> copay <b>\$18</b> copay <b>\$18</b> copay <b>\$18</b> copay	<b>\$18</b> copay <b>\$18</b> copay <b>\$18</b> copay <b>\$18</b> copay
<b>Outpatient group 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>\$13</b> copay <b>\$13</b> copay <b>\$18</b> copay <b>\$13</b> copay	<b>\$13</b> copay <b>\$13</b> copay <b>\$18</b> copay <b>\$13</b> copay
<b>SKILLED NURSING FACILITY</b>		
This plan covers up to 100 days in a SNF.  No 3-day hospital stay is required. Plan pays \$0 after 100 days.	<b>\$0</b> copay per day for days 1-20 <b>\$161</b> copay per day for days 21-100	<b>\$0</b> copay per day for days 1-20 <b>\$161</b> copay per day for days 21-100
<b>AMBULANCE</b>		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	<b>\$0</b> copay	<b>\$0</b> copay
<b>MEDICARE PART B PRESCRIPTION DRUGS</b>		
<b>Chemotherapy drugs</b> <ul style="list-style-type: none"><li>Specialist's office</li><li>Outpatient Hospital</li></ul>	<b>\$0</b> copay <b>\$0</b> copay	<b>\$0</b> copay <b>\$0</b> copay

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# Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>Medicare Part B covered drugs</b>		
• Primary care provider (PCP)	<b>\$0</b> copay	<b>\$0</b> copay
• Specialist's office	<b>\$0</b> copay	<b>\$0</b> copay
• Outpatient Hospital	<b>\$0</b> copay	<b>\$0</b> copay
• Pharmacy	<b>\$0</b> copay	<b>\$0</b> copay
<b>Medicare Part B insulin drugs</b>		
• Primary care provider (PCP)	<b>\$0</b> copay	<b>\$0</b> copay
• Specialist's office	<b>\$0</b> copay	<b>\$0</b> copay
• Outpatient Hospital	<b>\$0</b> copay	<b>\$0</b> copay
• Pharmacy	<b>\$0</b> copay	<b>\$0</b> copay
<b>ACUPUNCTURE SERVICES</b>		
<b>Medicare-covered acupuncture visit(s) for chronic low back pain</b>	<b>\$0</b> copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year.	<b>\$0</b> copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
<b>ALLERGY</b>		
<b>Allergy shots &amp; serum</b>		
• Primary care provider (PCP)	<b>\$13</b> copay	<b>\$13</b> copay
• Specialist's office	<b>\$18</b> copay	<b>\$18</b> copay
<b>CHIROPRACTIC SERVICES</b>		
<b>Medicare-covered chiropractic visit(s)</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>Routine chiropractic visit(s)</b>	<b>20%</b> of the cost for routine chiropractic visits up to 18 combined in and out of network visit(s) per year.	<b>20%</b> of the cost for routine chiropractic visits up to 18 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>DIABETES SERVICES AND SUPPLIES</b>		
<b>Continuous glucose monitor (CGM)</b>		
• Durable medical equipment provider	<b>0%</b> of the cost	<b>0%</b> of the cost
• Pharmacy	<b>0%</b> of the cost	<b>0%</b> of the cost

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# Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>Diabetes management training</b>		
• Primary care provider (PCP)	<b>\$0</b> copay	<b>\$0</b> copay
• Specialist's office	<b>\$0</b> copay	<b>\$0</b> copay
• Outpatient hospital	<b>\$0</b> copay	<b>\$0</b> copay
<b>Diabetes monitoring supplies</b>		
• Durable medical equipment provider	<b>\$0</b> copay	<b>\$0</b> copay
• Pharmacy	<b>\$0</b> copay	<b>\$0</b> copay
• Preferred diabetic supplier	<b>\$0</b> copay	Not Covered
<b>Diabetes screening</b>		
• Primary care provider (PCP)	<b>\$0</b> copay	<b>\$0</b> copay
• Specialist's office	<b>\$0</b> copay	<b>\$0</b> copay
<b>FOOT CARE (PODIATRY)</b>		
<b>Medicare-covered foot care</b>	<b>\$18</b> copay	<b>\$18</b> copay
<b>Routine foot care</b>	<b>\$18</b> copay for routine podiatry visits up to 6 combined in and out of network visit(s) per year.	<b>\$18</b> copay for routine podiatry visits up to 6 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>HOME HEALTH CARE</b>		
	<b>\$0</b> copay	<b>\$0</b> copay
<b>HOSPICE</b>	You must get care from a Medicare-certified hospice. You must consult with your plan at <b>1-800-747-0008</b> before you select hospice.	
<b>MEDICAL EQUIPMENT/SUPPLIES</b>		
<b>Durable medical equipment</b>		
• Durable medical equipment provider	<b>0%</b> after combined annual deductible	<b>0%</b> after combined annual deductible
• Pharmacy	<b>0%</b> after combined annual deductible	<b>0%</b> after combined annual deductible
<b>Medical supplies (includes but not limited to: catheters, IV set-up and supplies)</b>		
• Medical supply provider	<b>0%</b> of the cost	<b>0%</b> of the cost
• Pharmacy	<b>0%</b> of the cost	<b>0%</b> of the cost
<b>Prosthetics (artificial limbs or braces)</b>		
• Prosthetics provider	<b>0%</b> of the cost	<b>0%</b> of the cost

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# Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>Compression stockings</b>		
• Durable medical equipment provider	<b>\$0</b> copay	<b>\$0</b> copay
• Pharmacy	<b>\$0</b> copay	<b>\$0</b> copay
4 pair(s) per year		
<b>OUTPATIENT SUBSTANCE ABUSE</b>		
<b>Outpatient individual substance abuse treatment visits</b>		
• Primary care provider (PCP)	<b>\$18</b> copay	<b>\$18</b> copay
• Specialist's office	<b>\$18</b> copay	<b>\$18</b> copay
• Urgent care	<b>\$18</b> copay	<b>\$18</b> copay
• Outpatient hospital	<b>\$18</b> copay	<b>\$18</b> copay
<b>Outpatient group substance abuse treatment visits</b>		
• Primary care provider (PCP)	<b>\$13</b> copay	<b>\$13</b> copay
• Specialist's office	<b>\$13</b> copay	<b>\$13</b> copay
• Urgent care	<b>\$18</b> copay	<b>\$18</b> copay
• Outpatient hospital	<b>\$13</b> copay	<b>\$13</b> copay
<b>REHABILITATION SERVICES</b>		
<b>Audiology Therapy</b>		
• Specialist's office	<b>\$0</b> copay	<b>\$0</b> copay
• Comprehensive outpatient rehab facility	<b>\$0</b> copay	<b>\$0</b> copay
• Outpatient hospital	<b>\$0</b> copay	<b>\$0</b> copay
<b>Cardiac rehabilitation</b>		
• Specialist's office	<b>\$0</b> copay	<b>\$0</b> copay
• Outpatient hospital	<b>\$0</b> copay	<b>\$0</b> copay
<b>Occupational therapy</b>		
• Specialist's office	<b>\$0</b> copay	<b>\$0</b> copay
• Comprehensive outpatient rehab facility	<b>\$0</b> copay	<b>\$0</b> copay
• Outpatient hospital	<b>\$0</b> copay	<b>\$0</b> copay
<b>Physical therapy</b>		
• Specialist's office	<b>\$0</b> copay	<b>\$0</b> copay
• Comprehensive outpatient rehab facility	<b>\$0</b> copay	<b>\$0</b> copay
• Outpatient hospital	<b>\$0</b> copay	<b>\$0</b> copay

**Note:** This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](http://Humana.com/PAL).



# Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>Pulmonary rehabilitation</b>		
• Specialist's office	<b>\$0</b> copay	<b>\$0</b> copay
• Comprehensive outpatient rehab facility	<b>\$0</b> copay	<b>\$0</b> copay
• Outpatient hospital	<b>\$0</b> copay	<b>\$0</b> copay
<b>Speech therapy</b>		
• Specialist's office	<b>\$0</b> copay	<b>\$0</b> copay
• Comprehensive outpatient rehab facility	<b>\$0</b> copay	<b>\$0</b> copay
• Outpatient hospital	<b>\$0</b> copay	<b>\$0</b> copay
<b>RENAL DIALYSIS</b>		
<b>Renal dialysis services</b>		
• Dialysis center	<b>\$0</b> copay	<b>\$0</b> copay
• Outpatient hospital	<b>\$0</b> copay	<b>\$0</b> copay
<b>Kidney disease education services</b>		
• Primary care provider (PCP)	<b>\$0</b> copay	<b>\$0</b> copay
• Specialist's office	<b>\$0</b> copay	<b>\$0</b> copay
• Outpatient hospital	<b>\$0</b> copay	<b>\$0</b> copay
<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>Substance abuse or behavioral health services</b>	<b>\$0</b> copay	Not Covered
<b>TRANSPORTATION</b>		
<b>Uniform Flexibility Non-Emergency Medical 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. This benefit offers unlimited 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.

**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](http://Humana.com/PAL).

 Additional Benefits**FITNESS AND WELLNESS**

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

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

**HEALTH EDUCATION SERVICES**

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

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

**POST-DISCHARGE SERVICES**

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

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

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

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

**SMOKING CESSATION (ADDITIONAL)**

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

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

**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](http://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 مجاناً. اتصل على الرقم **877-320-1235 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլնտրանսլային ծևառափի ծառայություններ: Չանգահարեք՝ **877-320-1235 (TTY: 711)**:

বাংলা [Bengali]: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যসে 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 કોલ કરો.

עברית [Hebrew]: שירותי 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]: សេវាកម្មផ្លូវការភាសា ជំនួយ និង សេវាកម្មជាណម័យផ្លូវការភាសាខ្មែរ 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]: ມີການປ່ຽນປັນພາສາ, ອັບກອນຈ່າຍເຫັນ ອະນະ ດຸບແບບທາງເວົ້າກອັນໃຫ້ໄວ້ຟົດ. ໂທ 877-320-1235 (TTY: 711).

Diné [Navajo]: Saad t'áá jiik'eh, t'áadoole'é binahjí' bee adahodoonílgíí diné bich'í' anídahazt'i'i, dóó lahgo át'éego bee hada'dilyaaígíí bee bika'aanída'awo'í dahólq. Kohjí' hodílnih 877-320-1235 (TTY: 711).

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

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

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

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

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

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

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

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్రాద్య ఫార్మేట్ 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]: አንድ: አገዛ ማቅረብ እና አማራር ቅዱት የለችው አገልግሎቶችም ይገኛል:: በ 877-320-1235 (TTY: 711) ላይ ይደምላ::

Bāsəɔ̄́ [Bassa]: Wuqu-xwíñíñ-mú-zà-zà kùà, Hwòdō-fíñó-ñyɔ́, kè nyɔ́-bɔ́ññ-po-kà bě bé nyuee se wídí pèè-péè dò kò. 877-320-1235 (TTY: 711) dá.

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

Òyìnbó [Yoruba]: Àwọn isé àtìlèhìn ìrànlówó èdè, àti ọnà kíkà míràn wà láròwótó. Pe 877-320-1235 (TTY: 711).

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



Find out **more**



You can see this plan's provider directory at **[your.Humana.com/peehip](http://your.Humana.com/peehip)** or call us at **1-800-747-0008** 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 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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