2026

Summary of Benefits

Humana Group Medicare Advantage PPO Plan
PPO 079/830

Pfizer - MA

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 **1-800-654-1092** for questions **(TTY/TDD: 711)**

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

Or visit our website: **https://your.humana.com/pfizer**

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 You must keep paying your Medicare Part B premium.	For information concerning the actual premiums you will pay, please call Fidelity at the Pfizer Benefits Center at 877-208-0950 (TTY: 711).
Medical deductible	**$150** 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** **$3,500** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; Acupuncture; Chiropractic Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Personal Emergency Response System; Podiatry Services (Routine); Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Private Duty Nursing; Smoking Cessation (Additional); Transportation (Routine); Uniform Flexibility Non-Emergency Medical Transportation; Vision Services (Routine) 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** **$3,500** out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy; Acupuncture; Chiropractic Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Personal Emergency Response System; Podiatry Services (Routine); Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Private Duty Nursing; Smoking Cessation (Additional); Transportation (Routine); 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, Acupuncture; Chiropractic Services (Routine); Hearing Services (Routine); Personal Emergency Response System; Podiatry Services (Routine); Private Duty Nursing; Transportation (Routine); 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.*

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.	**$500** per admit	**$500** per admit
OUTPATIENT HOSPITAL COVERAGE		
Diagnostic colonoscopy	**$350** copay	**$350** copay
Diagnostic mammography	**$25** copay	**$25** copay
Observation services	**$0** copay	**$0** copay
Surgery services	**$350** copay	**$350** copay
AMBULATORY SURGICAL CENTER		
Diagnostic colonoscopy	**$350** copay	**$350** copay
Surgery services	**$350** copay	**$350** copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$25** copay	**$25** copay
Specialists	**$40** copay	**$40** 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) 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 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.	**$125** copay for Medicare-covered emergency room visit(s)	**$125** copay for Medicare-covered emergency room visit(s)
Urgently needed services		
• Primary care provider (PCP)	**$25** copay	**$25** copay
• Specialist's office	**$40** copay	**$40** copay
• Urgent care center	**$50** copay	**$50** 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)	**$25** copay	**$25** copay
• Specialist's office	**$25** copay	**$25** copay
• Freestanding radiological facility	**$25** copay	**$25** copay
• Outpatient Hospital	**$25** copay	**$25** copay
Diagnostic mammography		
• Primary care provider (PCP)	**$25** copay	**$25** copay
• Specialist's office	**$40** copay	**$40** copay
• Freestanding radiological facility	**$25** copay	**$25** copay
• Outpatient Hospital	**$25** copay	**$25** copay
Diagnostic procedures and tests		
• Primary care provider (PCP)	**$25** copay	**$25** copay
• Specialist's office	**$40** copay	**$40** copay
• Urgent care center	**$50** copay	**$50** copay
• Freestanding radiological facility	**$25** copay	**$25** copay
• Outpatient Hospital	**$25** copay	**$25** copay
EKG screening		
• Primary care provider (PCP)	**0%** of the cost	**0%** of the cost
• Specialist's office	**0%** of the cost	**0%** of the cost

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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
Lab services		
• Primary care provider (PCP)	**$25** copay	**$25** copay
• Specialist's office	**$25** copay	**$25** copay
• Urgent care center	**$25** copay	**$25** copay
• Freestanding laboratory	**$25** copay	**$25** copay
• Outpatient Hospital	**$25** copay	**$25** copay
Nuclear medicine services		
• Freestanding radiological facility	**$25** copay	**$25** copay
• Outpatient Hospital	**$25** copay	**$25** copay
Outpatient x-rays		
• Primary care provider (PCP)	**$25** copay	**$25** copay
• Specialist's office	**$40** copay	**$40** copay
• Urgent care center	**$50** copay	**$50** copay
• Freestanding radiological facility	**$25** copay	**$25** copay
• Outpatient Hospital	**$25** copay	**$25** copay
Radiation therapy		
• Specialist's office	**$25** copay	**$25** copay
• Freestanding radiological facility	**$25** copay	**$25** copay
• Outpatient Hospital	**$25** copay	**$25** copay
HEARING SERVICES		
Medicare-covered hearing: diagnostic hearing and balance exams	**$20** copay	**$20** copay
Routine hearing TruHearing Provider must be used. Contact Customer Service to locate a provider.	**$0** copay for routine hearing exams up to 1 per year. **$1,500** maximum benefit coverage amount for hearing aid(s) (all types) up to 2 every 3 years. 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	**$20** copay	**$20** copay

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
VISION SERVICES		
Medicare-covered vision services	**$20** copay	**$20** copay
Medicare-covered diabetic eye exam (1 per year)	**$0** copay	**$0** copay
Medicare-covered glaucoma screening (1 per year)	**0%** of the cost	**0%** of the cost
Medicare-covered eyewear (post-cataract)	**0%** of the cost	**0%** of the cost
Routine vision 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 calendar year. **$400** maximum benefit coverage amount toward eyeglass lenses and frames OR **$150** maximum benefit coverage amount toward the purchase of contact lenses (1 per calendar year). Lens options include single vision, lined bifocal and trifocal lenses, ultraviolet protection and scratch resistant coating.	**$175** maximum benefit coverage amount per year for routine exam (includes refraction). **$0** copay for routine exam (includes refraction) up to 1 per calendar year. **$400** maximum benefit coverage amount toward eyeglass lenses and frames OR **$150** maximum benefit coverage amount toward the purchase of contact lenses (1 per calendar year). Lens options include single vision, lined bifocal and trifocal lenses, ultraviolet protection and scratch resistant coating. 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.*

Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
PERSONAL EMERGENCY RESPONSE SYSTEM		
Personal Emergency Response System (PERS)	**$0** 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
MENTAL HEALTH SERVICES		
Inpatient The inpatient hospital care limit applies to inpatient mental services provided in a general hospital or a psychiatric facility. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. 190 day lifetime limit in a psychiatric facility.	**$500** per admit	**$500** per admit
Partial Hospitalization	**$55** copay	**$55** copay
Intensive Outpatient Services	**$55** copay	**$55** copay
Outpatient group and individual therapy visits		
• Primary care provider (PCP)	**$25** copay	**$25** copay
• Specialist's office	**$25** copay	**$25** copay
• Urgent care	**$50** copay	**$50** copay
• Outpatient Hospital	**$25** copay	**$25** 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.*

Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
SKILLED NURSING FACILITY		
This plan covers up to 100 days in a SNF. No 3-day hospital stay is required. Plan pays $0 after 100 days.	**$0** copay per day for days 1-20 **$75** copay per day for days 21-100	**$0** copay per day for days 1-20 **$75** copay per day for days 21-100
AMBULANCE		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	**$100** copay	**$100** copay
TRANSPORTATION		
Routine Transportation	**$0** copay for plan approved location up to 12 one-way trip(s) per year. 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
Uniform Flexibility Non-Emergency Medical Transportation	**$0** copay for plan approved location up to unlimited one-way trip(s) per year by car, rideshare services, van, wheelchair access vehicle for members with a Chronic Kidney Disease (CKD), End Stage Renal Disease (ESRD), or Cancer Diagnosis. This benefit is not to exceed 50 miles per trip.	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
MEDICARE PART B PRESCRIPTION DRUGS		
Chemotherapy drugs		
• Specialist's office	**$35** copay	**$35** copay
• Outpatient Hospital	**$35** copay	**$35** copay
Medicare Part B covered drugs		
• Primary care provider (PCP)	**20%** of the cost	**20%** of the cost
• Specialist's office	**20%** of the cost	**20%** of the cost
• Outpatient Hospital	**20%** of the cost	**20%** of the cost
• Pharmacy	**20%** of the cost	**20%** of the cost
Medicare Part B insulin drugs		
• Primary care provider (PCP)	**20%** of the cost	**20%** of the cost
• Specialist's office	**20%** of the cost	**20%** of the cost

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

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
• Pharmacy	**$0** copay	**$0** copay
Diabetes management training		
• Primary care provider (PCP)	**0%** of the cost	**0%** of the cost
• Specialist's office	**0%** of the cost	**0%** of the cost
• Outpatient hospital	**0%** of the cost	**0%** of the cost
Diabetes monitoring supplies		
• Durable medical equipment provider	**20%** of the cost	**20%** of the cost
• Pharmacy	**0%** of the cost	**0%** of the cost
• Preferred diabetic supplier	**$0** copay	Not Covered
Diabetes screening		
• Primary care provider (PCP)	**0%** of the cost	**0%** of the cost
• Specialist's office	**0%** of the cost	**0%** of the cost
Diabetic shoes and inserts		
• Prosthetics provider	**20%** of the cost	**20%** of the cost
• Durable medical equipment provider	**20%** of the cost	**20%** of the cost
FOOT CARE (PODIATRY)		
Medicare-covered foot care	**$20** copay	**$20** copay
Routine foot care	**$20** copay for routine podiatry visits up to 6 combined in and out of network visit(s) per year.	**$20** 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.
HOME HEALTH CARE		
	0% of the cost	**0%** of the cost
HOSPICE You must get care from a Medicare-certified hospice. You must consult with this plan before you select hospice.		
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment		
• Durable medical equipment provider	**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)	**$25** copay	**$25** copay
• Specialist's office	**$25** copay	**$25** copay
• Urgent care	**$50** copay	**$50** copay
• Outpatient hospital	**$25** copay	**$25** copay
PRIVATE DUTY NURSING		
• Member's home • Inpatient Hospital **$1,500** combined In & Out-of-Network maximum benefit coverage amount per year	**$0** copay	**$0** copay
REHABILITATION SERVICES		
Audiology Therapy		
• Specialist's office	**$25** copay	**$25** copay
• Comprehensive outpatient rehab facility	**$25** copay	**$25** copay
• Outpatient hospital	**$25** copay	**$25** copay
Cardiac rehabilitation		
• Specialist's office	**$25** copay	**$25** copay
• Outpatient hospital	**$25** copay	**$25** copay
Occupational therapy		
• Specialist's office	**$25** copay	**$25** copay
• Comprehensive outpatient rehab facility	**$25** copay	**$25** copay
• Outpatient hospital	**$25** copay	**$25** copay

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
Physical therapy		
• Specialist's office	**$25** copay	**$25** copay
• Comprehensive outpatient rehab facility	**$25** copay	**$25** copay
• Outpatient hospital	**$25** copay	**$25** copay
Pulmonary rehabilitation		
• Specialist's office	**$20** copay	**$20** copay
• Comprehensive outpatient rehab facility	**$20** copay	**$20** copay
• Outpatient hospital	**$20** copay	**$20** copay
Speech therapy		
• Specialist's office	**$25** copay	**$25** copay
• Comprehensive outpatient rehab facility	**$25** copay	**$25** copay
• Outpatient hospital	**$25** copay	**$25** 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%** of the cost	**0%** of the cost
• Specialist's office	**0%** of the cost	**0%** of the cost
• Outpatient hospital	**0%** of the cost	**0%** of the cost
HUMANA IN-NETWORK TELEHEALTH VENDORS, i.e. MDLive (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered
Specialist	**$0** copay	Not Covered
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered

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Additional Benefits

FITNESS AND WELLNESS	
	Live a healthier, more active life through fitness and social connection at participating SilverSneakers® locations and online. The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
HEALTH EDUCATION SERVICES	
	Personal Health Coaching is an interactive inbound and outreach on-line and telephonic wellness coaching for Medicare participants who elect to participate, for wellness improvement, including weight management, nutrition, exercise, back care, blood pressure management, and blood sugar management. The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
POST-DISCHARGE SERVICES	
	$0 copay for the following benefits per discharge event following each inpatient or skilled nursing facility stay: • Assistance from a qualified aid to help perform activities of daily living within the home. Minimum of 4 hours per day, up to a maximum of 8 hours. Types of assistance include bathing, dressing, toileting, walking, eating and preparing meals. • 2 meals per day for 14 days, up to 28 meals delivered to your door. • Transportation to plan approved locations by rideshare services, car, van or wheelchair accessible vehicle. Services must be provided by approved vendors, scheduled within 30 days of discharge event and utilized within 60 days of discharge. The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
SMOKING CESSATION (ADDITIONAL)	
	A comprehensive smoking cessation program available online, email and phone. Personal coaches assist via establishing goals and providing articles and resources to aid in the effort to quit smoking. The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

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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។ ទូរសព្ទទៅលេខ **877-320-1235 (TTY: 711)**។

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

ພາສາລາວ [Lao] ມີການບໍລິການດ້ານພາສາ, ອຸປະກອນຊ່ວຍເຫຼືອ ແລະ 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-ńyɔ,́ kè nyɔ-bɔǔn-po-kà ɓě ɓé nyuɛɛ se wíɖí péɛ̀-péɛ̀ 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 ।

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