Summary of Benefits

Humana Group Medicare Advantage PPO Plan PPO 079/831

Pfizer - Family



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: Humana.com

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 contact your employer group benefits plan administrator.

Medical deductible

Medical Maximum out-of-pocket responsibility

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

\$150 per year for some combined in- and out-of-network services

In-Network Maximum Out-of-Pocket \$3,400 out-of-pocket limit for Medicard

\$3,400 out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; 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; 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

\$3,400 out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy; 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; 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, Chiropractic Services (Routine); Hearing Services (Routine); Personal Emergency Response System; Podiatry Services (Routine); 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.

		Covered	Medical	Benefits
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	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CAR	E	
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.	\$250 copay per day for days 1-9	\$250 copay per day for days 1-9
OUTPATIENT HOSPITAL COVERAG	E	
Diagnostic colonoscopy	\$500 copay	\$500 copay
Diagnostic mammography	\$60 copay	\$60 copay
Observation services	\$0 copay	\$0 copay
Surgery services	\$500 copay	\$500 copay
AMBULATORY SURGICAL CENTER		
Diagnostic colonoscopy	\$500 copay	\$500 copay
Surgery services	\$500 copay	\$500 copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	\$15 copay	\$15 copay
Specialists	\$40 copay	\$40 copay



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

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 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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	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.	\$120 copay for Medicare-covered emergency room visit(s)	\$120 copay for Medicare-covered emergency room visit(s)
 Urgently needed services Primary care provider (PCP) Specialist's office Urgent care center Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. 	\$15 copay \$40 copay \$65 copay	\$15 copay \$40 copay \$65 copay
DIAGNOSTIC SERVICES, LABS AND) IMAGING	
Advanced imaging services (MRI, MRA, PET and CT Scan) • Primary care provider (PCP) • Specialist's office • Freestanding radiological facility • Outpatient Hospital	\$15 copay \$60 copay \$60 copay \$60 copay	\$15 copay \$60 copay \$60 copay \$60 copay
Diagnostic mammography Primary care provider (PCP) Specialist's office Freestanding radiological facility Outpatient Hospital	\$15 copay \$40 copay \$60 copay	\$15 copay \$40 copay \$60 copay
 Diagnostic procedures and tests Primary care provider (PCP) Specialist's office Urgent care center Freestanding radiological facility Outpatient Hospital 	\$15 copay \$40 copay \$65 copay \$60 copay	\$15 copay \$40 copay \$65 copay \$60 copay
EKG screeningPrimary care provider (PCP)Specialist's office	0% of the cost 0% of the cost	0% of the cost 0% of the cost

IN-NETWORK • Freestanding radiological facility • Outpatient Hospital 0% of the cost 0% of the cost 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 \$0 copay \$0 copay Nuclear medicine services • Freestanding radiological facility • Outpatient Hospital \$60 copay \$60 copay Outpatient Hospital \$60 copay \$60 copay
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Outpatient x-rays
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 Primary care provider (PCP) \$15 copay \$15 copay
• Specialist's office \$40 copay \$40 copay
• Urgent care center \$65 copay \$65 copay
 Freestanding radiological facility \$60 copay \$60 copay
• Outpatient Hospital \$60 copay \$60 copay
Radiation therapy
• Specialist's office \$40 copay \$40 copay
 Freestanding radiological facility \$60 copay \$60 copay
• Outpatient Hospital \$60 copay \$60 copay
HEARING SERVICES
Medicare-covered hearing: \$40 copay diagnostic hearing and balance exams \$40 copay
Routine hearing \$0 copay for routine hearing exams up to 1 per year. The in-network provider must used for this service. If you
TruHearing Provider must be used. Contact Customer Service to locate a provider. \$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.
DENTAL SERVICES
Medicare-covered dental \$40 copay \$40 copay

🧽 Covered Medical I	Benefits	
	IN-NETWORK	OUT-OF-NETWORK
VISION SERVICES		
Medicare-covered vision services	\$40 copay	\$40 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)	\$40 copay	\$40 copay
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 year.	\$175 combined maximum benefit coverage amount per year for routine exam (includes refraction). \$0 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.
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	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges

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.

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	IN-NETWORK	OUT-OF-NETWORK
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.	\$250 copay per day for days 1-7	\$250 copay per day for days 1-7
Partial Hospitalization	\$55 copay	\$55 copay
Intensive Outpatient Services	\$55 copay	\$55 copay
Outpatient group and individual therapy visits • Primary care provider (PCP) • Specialist's office • Urgent care • Outpatient Hospital	\$15 copay\$40 copay\$65 copay\$40 copay	\$15 copay\$40 copay\$65 copay\$40 copay
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\$178 copay per day for days 21-39\$0 copay per day for days 40-100	\$0 copay per day for days 1-20 \$178 copay per day for days 21-39 \$0 copay per day for days 40-100
AMBULANCE		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	\$175 copay	\$175 copay

Benefits	
IN-NETWORK	OUT-OF-NETWORK
\$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
\$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.
DRUGS	
\$75 copay \$75 copay	\$75 copay \$75 copay
0% of the cost0% of the cost20% of the cost20% of the cost	0% of the cost0% of the cost20% of the cost20% of the cost
20% of the cost20% of the cost20% of the cost20% of the cost	20% of the cost20% of the cost20% of the cost20% of the cost
	\$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. \$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. DRUGS \$75 copay \$75 copay \$75 copay \$76 of the cost \$775 copay

Covered Medical Benefits				
	IN-NETWORK	OUT-OF-NETWORK		
ACUPUNCTURE SERVICES				
Medicare-covered acupuncture visit(s) for chronic low back pain	\$40 copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year.	\$40 copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.		
ALLERGY				
Allergy shots & serum				
Primary care provider (PCP)Specialist's office	\$15 copay \$40 copay	\$15 copay \$40 copay		
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 SUPPLIE	:S			
Continuous glucose monitor (CGM)				
 Durable medical equipment provider 	\$0 copay	\$0 copay		
• Pharmacy	\$0 copay	\$0 copay		
Diabetes management trainingPrimary care provider (PCP)Specialist's officeOutpatient hospital	0% of the cost0% of the cost0% of the cost	0% of the cost0% of the cost0% of the cost		
Diabetes monitoring supplies				
Durable medical equipment provider	\$20 copay	\$20 copay		
• Pharmacy	0% of the cost	0% of the cost		
Preferred diabetic supplier	\$0 copay	Not Covered		
Diabetes screening				
Primary care provider (PCP)Specialist's office	0% of the cost 0% of the cost	0% of the cost 0% of the cost		
- Specialist's office	U /U UI LITE CUST	U /O OI LITE COSL		

	IN-NETWORK	OUT-OF-NETWORK
Diabetic shoes and insertsProsthetics providerDurable medical equipment provider	\$20 copay \$20 copay	\$20 copay \$20 copay
FOOT CARE (PODIATRY)		
Medicare-covered foot care	\$40 copay	\$40 copay
Routine foot care	\$40 copay for routine podiatry visits up to 6 combined in and out of network visit(s) per year.	\$40 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

MEDICAL EQUIPMENT/SUPPLIES			
Durable medical equipment			
 Durable medical equipment provider 	\$20 copay	\$20 copay	
• Pharmacy	\$20 copay	\$20 copay	
Medical supplies			
(includes but not limited to:			
catheters, IV set-up and			
supplies)			
 Medical supply provider 	0% of the cost	0% of the cost	
 Pharmacy 	0% of the cost	0% of the cost	
Prosthetics (artificial limbs or braces)			
 Prosthetics provider 	\$65 copay	\$65 copay	
OUTPATIENT SUBSTANCE ABUSE			
Outpatient group and individual substance abuse treatment visits			
 Primary care provider (PCP) 	\$15 copay	\$15 copay	
Specialist's office	\$40 copay	\$40 copay	
Urgent care	\$65 copay	\$65 copay	
Outpatient hospital	\$40 copay	\$40 copay	
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	Covered	Medical	Benefits

	IN-NETWORK	OUT-OF-NETWORK
REHABILITATION SERVICES		
Audiology Therapy		
 Specialist's office 	\$40 copay	\$40 copay
Comprehensive outpatient	\$40 copay	\$40 copay
rehab facility	***	***
Outpatient hospital	\$40 copay	\$40 copay
Cardiac rehabilitation	***	***
Specialist's office	\$40 copay	\$40 copay
Outpatient hospital	\$30 copay	\$30 copay
Occupational therapy		
 Specialist's office 	\$40 copay	\$40 copay
Comprehensive outpatient	\$40 copay	\$40 copay
rehab facility	¢/0 congy	¢(0 congy
Outpatient hospital	\$40 copay	\$40 copay
Physical therapy	* 10	A 10
• Specialist's office	\$40 copay	\$40 copay
 Comprehensive outpatient rehab facility 	\$40 copay	\$40 copay
 Outpatient hospital 	\$40 copay	\$40 copay
Pulmonary rehabilitation	4.0 copay	4.0 copay
 Specialist's office 	\$20 copay	\$20 copay
 Comprehensive outpatient 	\$20 copay	\$20 copay
rehab facility	+ _0 00 p 0 y	*
 Outpatient hospital 	\$20 copay	\$20 copay
Speech therapy		
 Specialist's office 	\$40 copay	\$40 copay
 Comprehensive outpatient 	\$40 copay	\$40 copay
rehab facility	***	A
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% 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
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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK				
HUMANA IN-NETWORK TELEHEALTH VENDORS, i.e. MDLive (in addition to Original Medicare)						
Primary care provider (PCP)	\$0 copay	Not Covered				
Specialist	\$40 copay	Not Covered				
Urgent care services	\$0 copay	Not Covered				
Substance abuse or behavioral health services	\$0 copay	Not Covered				

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.

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 1235-320 (الهاتف النصى: 711).

Յայերեն [Armenian]։ Յասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ։ Չանգահարե՛ ք՝ **877-320-1235 (ТТҮ: 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)**.

فارسى [Farsi]: خدمات زبان رايگان، كمك هاى اضافى و فرمت هاى جايگزين در دسترس است. با 1235-320-327 (TTY: 711) تماس بگيريد.

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, સહ્યયક સહ્યય 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 **717: 711) 877-320-1235**

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. GHHNOA2025HUM_0425

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 សេវាកម្មជាទម្រងផ្សេងជំនួសអាចរកបាន។ 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 binahji' bee adahodoonílígíí diné bich'i' anídahazt'i'í, dóó lahgo át'éego bee hada'dilyaaígíí bee bika'aanída'awo'í dahóló. Kohji' 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 [పత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **877-320-1235 (TTY: 711)** కి కాల్ చేయండి.

اردو:[Urdu] مفت زبان، معاون امداد، اور متبادل فارمیث کی خدمات دستیاب ہیں۔ کال (TTY: 711) 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፣ አ*ጋ*ዠ ማዳ**ጣ**ጫ *እ*ና አማራጭ ቅርፀት ያላቸው *አገል*ግሎቶችም ይ*ገ*ኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

Băsoó [Bassa]: Wudu-xwíníín-mú-zà-zà kằà, Hwòdŏ-fońo-nyo, kè nyo-boằn-po-kà bě bé nyuεε se wídí péè-péè dò ko. 877-320-1235 (TTY: 711) dá.

Bekee [Igbo]: Asusu n'efu, enyemaka nkwaru, na oru usoro ndi ozo di. Kpoo 877-320-1235 (TTY: 711).

Òyìnbó [Yoruba]: Àwọn işé àtìlẹhìn ìrànlówó èdè, àti ònà kíkà míràn wà lárowótó. 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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