2027

Summary of Benefits

Humana Group Medicare Advantage PPO Plan
PPO 079/886

Colorado PERA - Plan 1 - Part B Only



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 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 **866-373-7210** for questions **(TTY/TDD: 711)**

Call Monday – Friday, 8 a.m. - 10 p.m., Mountain Time.

Or visit our website: **your.humana.com/peracare**

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 group benefits plan administrator.
Medical deductible	This plan does not have a deductible.
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** **$2,000** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Uniform Flexibility Non-Emergency Medical Transportation; Uniform Flexibility Virtual Cardiac Recovery Program; 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** **$2,000** out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy; 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; Uniform Flexibility Virtual Cardiac Recovery Program; Vision Services (Routine) and the Plan Premium do not apply to the combined maximum out-of-pocket. Out-of-Network Exclusions: Part D Pharmacy, Fitness Program; Hearing Services (Routine); Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Uniform Flexibility Non-Emergency Medical Transportation; Uniform Flexibility Virtual Cardiac Recovery Program; 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. **$900** Maximum Out-of-Pocket per year	**$300** per admit	**$300** per admit
OUTPATIENT HOSPITAL COVERAGE		
Diagnostic colonoscopy	**$0** copay	**$0** copay
Diagnostic mammography	**$0** copay	**$0** copay
Observation services	**$0** copay	**$0** copay
Surgery services	**$0** copay	**$0** copay
AMBULATORY SURGICAL CENTER		
Diagnostic colonoscopy	**$0** copay	**$0** copay
Surgery services	**$0** copay	**$0** copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**$0** copay
Specialists	**$0** copay	**$0** 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 72 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.	**$50** copay for Medicare-covered emergency room visit(s)	**$50** copay for Medicare-covered emergency room visit(s)
Urgently needed services		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• 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. If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay the "Urgent care center" copay. See the "Inpatient Hospital Care" section of this booklet for other costs.	**$0** copay	**$0** copay
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	**$0** copay	**$0** copay
• Freestanding radiological facility	**$0** copay	**$0** copay
• Outpatient Hospital	**$0** copay	**$0** copay
Diagnostic mammography		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• Freestanding radiological facility	**$0** copay	**$0** copay
• Outpatient Hospital	**$0** copay	**$0** copay
Diagnostic procedures and tests		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• Urgent care center	**$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
EKG screening		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• 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	**$0** copay	**$0** copay
Nuclear medicine services		
• Freestanding radiological facility	**$0** copay	**$0** copay
• Outpatient Hospital	**$0** copay	**$0** copay
Outpatient x-rays		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• Urgent care center	**$0** copay	**$0** copay
• Freestanding radiological facility	**$0** copay	**$0** copay
• Outpatient Hospital	**$0** copay	**$0** copay
Radiation therapy		
• Specialist's office	**$0** copay	**$0** copay
• Freestanding radiological facility	**$0** copay	**$0** copay
• Outpatient Hospital	**$0** copay	**$0** copay
HEARING SERVICES		
Medicare-covered hearing: diagnostic hearing and balance exams	**$0** copay	**$0** copay

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
Routine hearing	**$0** copay for routine hearing exams up to 1 per year (includes hearing aid fitting). **$0** copay for follow-up provider visits up to 3 per year. **$500** maximum benefit coverage amount for hearing aid(s) (all types) up to 2 every 3 years. Note: Includes 3 years of batteries per non-rechargeable aid (up to 60 cells per ear, per year) and 3 year warranty. Three follow-up provider visits during first year following hearing aid purchase, with the original provider.	**95%** of the cost for routine hearing exams up to 1 per year. **95%** of the cost for follow-up provider visits up to 3 per year. **95%** of the cost for each prescription hearing aid up to 2 every 3 years. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to **5%** of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
DENTAL SERVICES		
Medicare-covered dental	**$0** copay	**$0** copay
VISION SERVICES		
Medicare-covered vision services	**$0** copay	**$0** 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)	**$0** copay	**$0** copay

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
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. **$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).	**$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). **$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). Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
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. **$900** Maximum Out-of-Pocket per year	**$300** per admit	**$300** per admit
Partial Hospitalization	**$0** copay	**$0** copay
Intensive Outpatient Services	**$0** copay	**$0** copay
Outpatient group and individual therapy visits		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• Urgent care	**$0** copay	**$0** copay
• Outpatient Hospital	**$0** copay	**$0** 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 (SNF)		
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 **$65** copay per day for days 21-50 **$0** copay per day for days 51-100	**$0** copay per day for days 1-20 **$65** copay per day for days 21-50 **$0** copay per day for days 51-100
AMBULANCE		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	**$75** copay	**$75** copay

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
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.	**95%** of the cost for plan approved location up to 12 one-way trip(s) per year. This benefit is not to exceed 50 miles per trip. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to **5%** of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Uniformity 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.	**95%** coinsurance for plan approved location by car, rideshare services, van, wheelchair access vehicle for members with a Chronic Kidney Disease (CKD), End Stage Renal Disease (ESRD), or Cancer Diagnosis. This benefit is not to exceed 50 miles per trip. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to 5% of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

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

Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
MEDICARE PART B PRESCRIPTION DRUGS		
Chemotherapy drugs		
• Specialist's office	**$0** copay	**$0** copay
• Outpatient Hospital	**$0** copay	**$0** copay
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	**0%** of the cost	**0%** 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	**$0** copay	**$0** copay
ACUPUNCTURE SERVICES		
Medicare-covered acupuncture visit(s) for chronic low back pain	**$0** copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year.	**$0** 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)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	**$0** copay	**$0** 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.

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
DIABETES SERVICES AND SUPPLIES		
Continuous glucose monitor (CGM)		
• Durable medical equipment provider	**0%** of the cost	**0%** of the cost
• Pharmacy	**0%** of the cost	**0%** of the cost
• Preferred Pharmacy	**$0** copay	Not Covered
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	**$0** copay	**$0** copay
• Pharmacy	**$0** copay	**$0** copay
• 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	**$0** copay	**$0** copay
Routine foot care	**$0** copay for routine podiatry visits up to 6 combined in and out of network visit(s) per year.	**$0** 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 copay	**$0** copay
HOSPICE You must get care from a Medicare-certified hospice. You must consult with this plan before you select hospice.		
• Inpatient hospital	**$0** copay	**$0** copay
• Outpatient hospital	**$0** copay	**$0** copay
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment		
• Durable medical equipment provider	**0%** of the cost	**0%** of the cost

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

	IN-NETWORK	OUT-OF-NETWORK
• Pharmacy	**0%** of the cost	**0%** of the cost
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	**0%** of the cost	**0%** 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	**$0** copay	**$0** copay
• Urgent care	**$0** copay	**$0** copay
• Outpatient hospital	**$0** copay	**$0** copay
REHABILITATION SERVICES		
Audiology Therapy		
• Specialist's office	**$0** copay	**$0** copay
• Comprehensive outpatient rehab facility	**$0** copay	**$0** copay
• Outpatient hospital	**$0** copay	**$0** copay
Cardiac rehabilitation		
• Specialist's office	**$0** copay	**$0** copay
• Outpatient hospital	**$0** copay	**$0** copay
Occupational therapy		
• Specialist's office	**$0** copay	**$0** copay
• Comprehensive outpatient rehab facility	**$0** copay	**$0** copay
• Outpatient hospital	**$0** copay	**$0** copay
Physical therapy		
• Specialist's office	**$0** copay	**$0** copay
• Comprehensive outpatient rehab facility	**$0** copay	**$0** copay
• Outpatient hospital	**$0** copay	**$0** copay
Pulmonary rehabilitation		
• Specialist's office	**$0** copay	**$0** copay
• Comprehensive outpatient rehab facility	**$0** copay	**$0** copay

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	IN-NETWORK	OUT-OF-NETWORK
• Outpatient hospital	**$0** copay	**$0** copay
Speech therapy		
• Specialist's office	**$0** copay	**$0** copay
• Comprehensive outpatient rehab facility	**$0** copay	**$0** copay
• Outpatient hospital	**$0** copay	**$0** copay
RENAL DIALYSIS		
Renal dialysis services		
• Dialysis center	**$0** copay	**$0** copay
• Outpatient hospital	**$0** copay	**$0** copay
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	**$0** copay	Not Covered
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered

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

Additional Benefits

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

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Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
POST-DISCHARGE SERVICES		
• 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 up to 12 one-way trips to plan approved locations by rideshare services, car, van or wheelchair accessible vehicle. • This benefit is not to exceed 100 miles per trip. • In-network services must be scheduled by approved vendors, scheduled within 30 days of discharge event and utilized within 60 days of discharge.	**$0** copay per discharge event following each inpatient or skilled nursing facility stay.	**95%** coinsurance for out-of-network post-discharge services. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to 5% of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
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.	**$0** copay	Not Applicable

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Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
UNIFORMITY FLEXIBILITY VIRTUAL CARDIAC RECOVERY		
Delivered via telehealth, virtual cardiac recovery program provides up to 36 covered sessions to support recovery and reduce the risk of hospital readmission.	**$0** copay	**95%** coinsurance for cardiac recovery services provided via telehealth under virtual supervision by a physician or qualified practitioner. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to 5% of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

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

Notes

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)**.

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

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

Bǎsóò [Bassa]: Wudu-xwíníín-mú-zà-zà kǔà, hwòdǒ-fónɔ́-nyɔ̀,, kè nyɔ-bɔ̌-po-kà ɓě ɓé wa nyuɛsé wídí péè-péèdò kɔ̀. Ɓá **877-320-1235 (TTY: 711)**.

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

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

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

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

Hrvatski [Croatian]: Dostupne su besplatne jezične usluge, usluge dodatne pomoći i alternativnog formata. Nazovite **877-320-1235 (TTY: 711)**.

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

Français [French]: Des services gratuits d’assistance linguistique, d’aide auxiliaire et de format alternatif sont disponibles. Appelez le **877-320-1235 (ATS : 711)**.

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

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

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

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

हिंदी [Hindi]: निःशुल्क भाषा, सहायक मदद और वैकल्पिक प्रारूप सेवाएं उपलब्ध हैं। **877-320-1235 (TTY:711)** पर कॉल करें।

Hmoob [Hmong]: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **877-320-1235 (TTY: 711)**.

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

GHHNOA2026HUM_0526

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

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

ភាសាខ្មែរ [Khmer]៖ សេវាកម្មផ្នែកភាសា ជំនួយ និង 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]: ມີບໍລິການພາສາ, ອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ຮູບແບບທາງເລືອກອື່ນບໍ່ເສຍຄ່າໃຫ້. ໂທ **877-320-1235 (TTY: 711)**.

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

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

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

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

ਪੰਜਾਬੀ [Punjabi]: 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]: மொழி,, உதவிப் பொருட்கள் மற்றும் மாற்று வடிவமைப்புச் சேவைகள் இலவசமாகக் கிடைக்கின்றன. **877-320-1235 (TTY: 711)** எண்ணை அழைக்கவும்.

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

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

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

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

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

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